Welcome to **BURLOAK DENTAL** *Creating Beautiful Smiles*

MEDICAL ALERT

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Name: Last _____ First _____ Initial ___ Adult ☐ Child ☐ Date of Birth: ___ /___ /___

Address: _____ Telephone: _____
No. Street City Postal Code DD MM YY

Person Responsible for Account: Self ☐ Other ☐ Name: _____ Telephone: _____

Parent or Guardians Name (if Child): _____ Address if Different: _____

Your Occupation: _____ Employer: _____ Telephone: _____

In Case of Emergency Notify: _____ Relationship: _____ Telephone: _____

Family Physician: _____ Address: _____ Telephone: _____

Who may we thank for referring you to this office? _____

DENTAL INSURANCE YES☐ NO☐

Name of Insurance Company: _____ Name of Subscriber: _____

Date of Birth: ___/___/___ Group/Policy No. _____ Div. /Cert. No. _____
DD MM YY

Second Carrier

Name of Insurance Co mpany: _____ Name of Subscriber: _____

Date of Birth: ___/___/___ Group/Policy No. _____ Div. /Cert. No. _____
DD MM YY

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment

ALL INFORMATION IS CONFIDENTIAL

1. Are you in good health? _____ ☐YES ☐NO
2. Are you presently under the care of a physician? _____ ☐YES ☐NO
3. Have you ever had a serious illness requiring hospitalization or extensive medical care? _____ ☐YES ☐NO

Please specify: _____

4. Do you use any prescription or non -prescription drugs regularly? _____ ☐YES ☐NO

Please specify: _____

5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex? _____ ☐YES ☐NO
6. Do any allergic reactions result in headaches, shortness of brea th, chest constriction, nausea? _____ ☐YES ☐NO

Please specify: _____

7. Have you ever experienced any unusual reaction to any of the following? (Please circle) _____ ☐YES ☐NO

Local anesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, ba rbiturates (sleeping pills), or any other medicine?

If so please explain: _____

8. Have you ever fainted? _____ ☐YES ☐NO
9. Have you been warned about taking any drug or medication? _____ ☐YES ☐NO
10. Do you bruise easily or b leed abnormally? _____ ☐YES ☐NO
11. Have you ever had any organ implants or medical implants? _____ ☐YES ☐NO
12. Do you have AIDS or have you ever tested positive for HIV? _____ ☐YES ☐NO
13. Do you have Hepatitis A, B, or C? _____ ☐YES ☐NO
14. Have you had any injury, surgery or x -ray therapy to your face or jaws? _____ ☐YES ☐NO
15. Do you have any of the following? Please check any that apply _____ ☐YES ☐NO

☐ Heart murmur / Mitral Valve Prolapse	☐ Epilepsy or Seizures	☐ Herpes	☐ Anemia	☐ Diabetes
☐ Stomach /Intestinal Problems	☐ Malignant Hyperthermia	☐ Liver Disease	☐ Blood Disorder	☐ Stroke
☐ Joint Replacement (hip, knee, etc.)	☐ Drug/Alcohol Dependency	☐ Heart Attack	☐ Pacemaker	☐ Cancer
☐ Mental or Nervous Disorder	☐ Venereal Disease	☐ Cold Sores	☐ Hay Fever	☐ Jaundice
☐ High/low Blood Pressure	☐ Lung Disease (i.e. Asthma)	☐ Kidney Disease	☐ Hemorrhage	
☐ Hyper (hypo) Glycemia	☐ Arthritis or Rheumatism	☐ Tuberculosis	☐ Thyroid Disease	
☐ Cortisone/Steroid Therapy	☐ Scarlett or Rheumatic Fever	☐ Sinus Trouble	☐ Migraine Headaches	

Other: _____

16. Do you have any disease, condition, or problem that you think the doctor should know about? _____ ☐ YES ☐ NO
17. WOMEN ONLY - Are you pregnant or suspect you might be? I f so, what month are you in? _____ ☐ YES ☐ NO
Are you taking birth control pills? _____ ☐ YES ☐ NO

DENTAL HISTORY

1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other _____
Are you currently having dental pain? _____ ☐ YES ☐ NO
2. How frequently do you see your dentist? ☐ 6 months ☐ yearly ☐ Other _____
Former Dentist: _____ Last dental visit: _____
Last cleaning: _____ Last dental x -rays: _____
3. Do you feel you have bad breath at times? _____ ☐ YES ☐ NO
4. Have you ever had jaw joint surgery or dental implants? _____ ☐ YES ☐ NO
5. Does any part of your mouth hurt when clenched? _____ ☐ YES ☐ NO
6. Have you had: ☐ Braces ☐ Oral surgery ☐ Gum treatment ☐ Root Canal ☐ Teeth e xtracted
7. Have you ever experienced any growths or sore spots in your mouth? If so, where? _____ ☐ YES ☐ NO
8. Are any of your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other
9. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Spontan eously
10. Do you catch food between your teeth? _____ ☐ YES ☐ NO
11. Are you aware of any loose teeth? _____ ☐ YES ☐ NO
12. Have you ever had a full mouth series of x -rays? _____ ☐ YES ☐ NO
13. Does your jaw crack, pop or grate when you open w idely? _____ ☐ YES ☐ NO
14. Are you satisfied with the appearance of your teeth? Please specify: _____ ☐ YES ☐ NO
15. Chief Complaint: _____

Office Policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it may be necessary to charge for the time lost. Office policy is that services are paid for at each visit as they are performed.

Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us.They are all trained in the appropriate uses and protection of your information. Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information, we will seek your approval in advance. Your information may be accessed by the regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under RHPA, and for the defense of a legal issue. Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Release and Consent: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary

for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine, and I will assume responsibility for fees associated with these services. I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time.

_____ ___/___/___ _____

(Signature) F Patient F Parent F Guardian DD MM YY Reviewing Dentist

MEDICAL HISTORY UPDATES DATE: _____

Have there been any changes to your medical history? _____

Have you had any serious illness? _____

Are you taking any new medication? _____

Are you under the care of a physician? _____

Have you changed your family physician? _____

Are you pregnant or suspect you might be? _____