BAYSHORE
DENTAL CENTRE

Patient Medical History Form

We appreciate the confidence you place with us to provide your dental services.

All information provided in this form will remain confidential. The dental administration staff is available to help you complete any portion of this form. Full completion of the forms will allow us to provide you with the highest standard of dental care. Thank you for your co-operation.

Date (DD/MM/YYYY): _____/_____/_____ Medical Alert: _____

Personal Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Email Address: _____ Primary Phone Number: _____

Emergency Contact: (Name & Relationship) _____ (Number)_____

Medical Doctor: _____ Phone: _____

Insurance Company Name: _____ Phone: _____

ID No.: _____ Policy No.: _____

Secondary Insurance Company: _____

ID No.: _____ Policy No.: _____

Who may we thank for referring you? _____

Dental History

When was your last dental visit _____ Last X-rays _____

How frequently do you see a dentist •3-6 months •Annually •Other _____

Are your teeth sensitive to: • Hot • Cold • Sweets • No

Do your gums feel swollen and tender? •Yes •No

Do your gums bleed when: • Brushing • Flossing • No Bleeding

History of any periodontal therapy •Yes •No

Do you grind or clench your teeth? •Yes •No

Does your jaw pop or crack when opening widely? •Yes •No

Have you had any prolonged bleeding following an extraction? •Yes •No

Do you have any sores or lumps in or near your mouth? _____

Are you satisfied with your teeth? •Yes •No _____

Have you ever had any problems/Anxiety with previous dental treatments? •Yes •No

What can we do to make you smile?

- Teeth Whitening
- White Fillings
- Replace Metal Fillings
- Eliminate Gaps
- Symmetrical Smile
- Correct Misaligned Teeth
- Gummy Smile
- Orthodontic Treatment
- Total Smi6le Makeover
- Broken/ Cracked Teeth
- Veneers
- Replace Missing Teeth
- Sleep Apnea/ Snoring
- Dental Implants
- Cosmetic Dentures
- Gum Laser Treatment
- Neuromuscular Dentistry
- Oral Conscious Sedation

Medical History – A Holistic Approach

Dental professionals primarily treat the area in and around your mouth, but since your mouth is part of your body, any medication you are taking, and your health history have an important relationship with your Dental Treatment. Please answer the following questions.

Are you under a physicians care right now? •Yes •No

_____

Have you been hospitalized or had a major operation? •Yes •No

_____

Have you ever had a serious head or neck injury/ concussion? •Yes •No

_____

Do you use any form of tobacco or nicotine? •Yes •No

If yes, how many cigarettes per day _____

How many units of alcohol do you consume per week (1/2-pint beer = 1 unit): _____

List any Medications you are currently taking: _____

Are you on birth control pills? •Yes •No

Are you or could you be pregnant or nursing? •Yes •No

If pregnant, what is the expected delivery date _____

Please go over the following section and indicate which of the following you have or have had. If you need to add further information, please enter it at the end.

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hemophilia	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No

Please enter details or any further information.

_____

_____

Are you **allergic** to or have you had a reaction to any of the following?

- None
- Aspirin
- Codeine
- Sulfa Drugs
- Penicillin
- Acrylic
- Latex/rubber products
- Metal
- Other _____

Is there anything else you would like to mention that has not been covered in this form?

_____

_____

Do you have any requests to make your visits more comfortable?

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of patient, parent, or guardian: _____Date_____

Dentist/Hygienist: _____Date_____