Mackenzie DENTAL CENTRE

Welcome to our Dental Office

MEDICAL ALERT

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office.

Mr. ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** ☐ **Dr.** ☐ Given Name: _____ Marital Status: _____

Surname: _____ Pronunciation: _____ Prefer to be called _____

Address: (Street) _____ (Apt.#) _____ (City) _____ (Postal Code) _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X _____ Date of Birth: MM / DD / YY

Fax: (____) _____ - _____ Other: (____) _____ - _____ X _____ ☐ Male ☐ Female ☐ Adult ☐ Child

Employer / School: _____ Occupation: _____

eMail Address: _____ Contact Method _____

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

Are you likely to be available on short notice for future appointments ? ☐ Yes ☐ No

Family Physician: _____ Phone: (____) _____ - _____

In Case of Emergency Notify: _____ Relation: _____ Phone: (____) _____ - _____

Person responsible for this account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: _____

Name: (Last) _____ (First) _____ (Initial) _____ Relation: _____

Address: (Street) _____ (Apt.#) _____ (City) _____ (Postal Code) _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ X _____ Drivers Licence Number _____

Primary Insurance

Subscriber: _____ Date of Birth: _____

Relation: ☐ Self ☐ Spouse Other: _____

Subscriber I.D. _____ SIN _____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Secondary Insurance

Subscriber _____ Date of Birth: _____

Relation: ☐ Spouse Other: _____

Subscriber I.D. _____ SIN _____

Insurance Co: _____

Policy/Plan #: _____ Division/Sect. #: _____

Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Method of Payment ☐ Cash ☐ Cheque ☐ Credit Card: _____ Number: _____ Exp.: ___

MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

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

	YES	NO
1. Have you ever had a serious illness requiring hospitalization or extensive medical care? Please specify: _____	☐	☐
2. Are you presently under the care of a physician? If so, please explain: _____	☐	☐
3. Have you had a medical examination in the last year?	☐	☐
4. Do you use any prescription or non-prescription drugs regularly? Please specify: _____	☐	☐
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex?	☐	☐
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? Please specify: _____	☐	☐
7. Have you been hospitalized in the last 5 years? Please specify: _____	☐	☐
8. Have you ever experienced any unusual reaction to any of the following? (Please circle) local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? If so please explain _____	☐	☐
9. Have you been warned against taking any drug or medication?	☐	☐
10. Do you bruise easily or bleed abnormally?	☐	☐
11. Do you require pre-medication for dental treatment?	☐	☐

PATIENT REGISTRATION PLEASE COMPLETE BOTH SIDES **MEDICAL / DENTAL HISTORY**

	Yes	No
12. Have you ever had any organ implants or medical implants?	☐	☐
13. Have you ever fainted?	☐	☐
14. Do your ankles swell?	☐	☐
15. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
16. Do you have frequent headaches?	☐	☐
17. Do you have A.I.D.S. or have you ever tested positive for H.I.V.?	☐	☐
18. Do you have any of the following? Please check any that apply	☐	☐

☐ Heart Murmur or Mitral Valve Prolapse	☐ Malignant Hyperthermia	☐ Epilepsy or Seizures	☐ Herpes
☐ Stomach / Intestinal Problems / Ulcers	☐ Drug / Alcohol Dependency	☐ Liver Disease	☐ Sinus Trouble
☐ Joint Replacement (hip, knee, etc.)	☐ Venereal Disease	☐ Heart Attack	☐ Stroke
☐ Mental or Nervous Disorder	☐ Lung Disease (i.e. Asthma)	☐ Cold Sores	☐ Kidney Problems
☐ High Blood Pressure	☐ Thyroid Disease	☐ Jaundice	☐ Emphysema
☐ Low Blood Pressure	☐ Arthritis or Rheumatism	☐ Tuberculosis	☐ Glaucoma
☐ Hyper (hypo) Glycemia	☐ Scarlet or Rheumatic Fever	☐ Hepatitis A,B,C	☐ Diabetes
☐ Cortisone/Steroid Therapy	☐ Cancer / Chemotherapy	☐ Other: _____	

19. Have you had any injury, surgery or x-ray therapy to your face or jaws?		☐	☐
20. Do you have any disease, condition, or problem that you think the doctor should know about?		☐	☐
21. WOMEN ONLY -	Are you pregnant or suspect you might be? If so, what month are you in? _____	☐	☐
	Are you taking birth control pills?	☐	☐
	Are you nursing?	☐	☐

DENTAL HISTORY

	Yes	No
1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other _____		
Are you presently having dental pain?	☐	☐
Is there a dental problem you would like to take care of as soon as possible?	☐	☐
Please specify: _____		
2. How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other _____		
Last dental visit: _____		
Last cleaning: _____ Full mouth series of x-rays: _____		
3. How often do you brush your teeth? _____ Floss? _____		
4. Do your gums bleed easily?	☐	☐
5. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets?	☐	☐
6. Do you feel you have bad breath at times?	☐	☐
7. Have you ever had jaw joint surgery?	☐	☐
8. Do you have pain in your jaw joints or suffer from migraine headaches?	☐	☐
9. Does any part of your mouth hurt when clenched?	☐	☐
10. Does your jaw crack or pop when opened widely?	☐	☐
11. Have you had: ☐ Braces ☐ Oral surgery ☐ Gum treatment ☐ Root canal	☐	☐
12. Do you grind or clench your teeth during the day or night?	☐	☐
13. Do you smoke? Number per day: _____	☐	☐
14. Do you or does any family member have a problem with snoring?	☐	☐
15. Have you ever experienced any growths or sore spots in your mouth? If so, where? _____	☐	☐
16. Previous problems with dental treatment? Specify: _____	☐	☐
17. Are you satisfied with the appearance of your teeth?	☐	☐
Please specify: _____		
18. Other Dental Concerns: _____		

Privacy Act Notification: I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.

Office Policy: Your appointment time will be reserved 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.

Patient Release: 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 have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. 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.

	Date: MM / DD / YY	
(Signature) ☐ PATIENT ☐ PARENT ☐ GUARDIAN		REVIEWING DENTIST

Dr. Lloyd G. Pedvis Dentistry Professional Corporation

Please bring completed form to our office