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NAME: _____

LAST FIRST INITIAL NICKNAME

ADDRESS: _____

UNIT # BUILDING # STREET NAME CITY POSTAL CODE

HOME PHONE: _____ WORK: _____ EXT: _____

MOBILE: _____ EMAIL: _____

Birthday (Day/Month/Year): ____ / ____ / ____ Age: ____ Sex M / F

CARECARD Number: _____ NAME ON CARD: _____

WHO REFERRED YOU? _____ Phone no: _____

YOUR PHYSICIAN'S NAME: _____ Phone no: _____

DO YOU GO TO SCHOOL? YES / NO FULL TIME? YES / NO

SCHOOL NAME _____

FIRST INSURANCE PLAN

INSURANCE CARRIER _____

POLICY # _____ ID# _____ DOB _____

BASIC COVERAGE _____ % PLAN MAXIMUM \$ _____

INSURED'S NAME: _____ ADDRESS: _____

DOES YOUR INSURANCE POLICY HAVE A DEDUCTIBLE? YES / NO \$ _____

SECOND INSURANCE PLAN

INSURANCE CARRIER _____

POLICY # _____ ID# _____ DOB _____

BASIC COVERAGE _____ % PLAN MAXIMUM \$ _____

INSURED'S NAME: _____ ADDRESS: _____

CONFIDENTIAL MEDICAL QUESTIONNAIRE

In order to provide safe dental care for our patients, we ask you to answer the following questions as accurately as you can. If you have any questions or doubts, check the "not sure/maybe" choice. Your responses will be reviewed. Be assured that the information you provide will be kept in the strictest confidence. Please check the appropriate box on the right of the page under, "Yes", "Not sure/maybe", "No".

	Yes	Not sure/ maybe	No
> Are you being treated for any medical condition at present or have you been treated within the last year? Please give reason: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Has there been any change in your general health in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Are you taking any medications or non-prescription drugs of any kind? <i>If yes, please write their names below:</i> _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you have any allergies? <i>If yes, please list them below:</i> _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever had a peculiar reaction or adverse reaction to any medicines or injections? (e.g. penicillin, aspirin, or local anaesthetics, dental freezing?) <i>If yes, please describe:</i> _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you or any relatives had an unexplained or serious complication during surgery or anaesthesia? <i>If yes, please describe:</i> _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you have any heart or blood pressure problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever had rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you have, or have you ever had jaundice, hepatitis, or liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever been told that you should not give blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you have any conditions that could affect your immune system, e.g. AIDS, HIV positive, leukaemia, etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Have you ever been hospitalised for any serious illnesses or operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
> Do you have, or have you ever had, any of the following? <i>Please tick off only those that apply:</i>			
<input type="checkbox"/> chest pain	<input type="checkbox"/> bronchitis	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> arthritis
<input type="checkbox"/> epilepsy	<input type="checkbox"/> diabetes	<input type="checkbox"/> stroke	<input type="checkbox"/> asthma
<input type="checkbox"/> prosthetic joint	<input type="checkbox"/> drug/alcohol dependency	<input type="checkbox"/> Irradiation to the jaws for cancer	<input type="checkbox"/> heart attack
			<input type="checkbox"/> COPD
			<input type="checkbox"/> kidney disease

Are there any conditions not listed above that you have ever had? If you answered "yes", please list them:

Do you smoke or chew tobacco? **Yes** **No**

For women only: are you pregnant? **Yes** **No** *If yes, when is the expected delivery date?* _____

Follow up information to above questions: _____

My height (in inches): _____ and my weight (state kg or lb): _____ To the best of my knowledge, the above information is correct.

Signature of patient/guardian

(date)

Reviewed by treating dentist

(date)