Gilmour Dental Centre

Welcome to our Dental Office

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr.

Medical alert

Date: MM / DD / YYYY

Name: LAST FIRST ☐Male ☐Female

Address:

Home Phone ( ) -	**Work Phone** ( ) -	**Date of Birth:** MM / DD / YYYY **Place of Birth:**
Cell Phone ( ) -	**Fax** ( ) -	**Email:**

Employer/ School	**Occupation**

Whom may we thank for referring you to this office?

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

Family Physician: Tel. ( ) -

In Case of Emergency Notify: Relation: Tel. ( ) -

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

Name Relation:

Address

Phone: Home Work Cell

Method of Payment: ☐ Cash ☐ Cheque ☐ Credit Card: Nr: Exp:

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Subscriber:	Subscriber:
Relation: ☐ Self ☐ Spouse ☐ Other:	Relation: ☐ Self ☐ Spouse ☐ Other:
Insurance Co:	Insurance Co:
Policy/Plan #:	Policy/Plan #:
Subscriber I.D. or SIN #:	Subscriber I.D. or SIN #:

MEDICAL HISTORY Please check YES or NO to each question **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, specify:	☐	☐
3. Do you take any prescription or non- prescription medication? If yes, please list medication below:	☐	☐
4. **Do you have any allergy**? If yes, please circle: **Penicillin** **Codeine** **Sulfa drugs** **Latex** **Aspirin** **Local anaesthetic** (freezing) **Barbiturates** (sleeping pills) **Other**:	☐	☐
5. Have you been warned against taking any drug or medication?	☐	☐
6. Do you bruise easily or bleed abnormally?	☐	☐
7. Have you been hospitalized in the past 5 years? Please specify:	☐	☐
8. Did you have any knee / hip replacement? **Hip** L R Year: **Knee** L R Year: Other:	☐	☐
9. Have you ever had any organ implants or medical implants?	☐	☐
10. Do you have a **pacemaker**?	☐	☐
11. Have you ever fainted?	☐	☐

MEDICAL HISTORY (cont'd) **Please check YES or NO to each question**	YES	NO
12. Do your ankles, feet or hands swell?	☐	☐
13. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
14. Do you have frequent headaches?	☐	☐
15. Do you have A.I.D.S. or have you ever tested positive to H.I.V.?	☐	☐
16. Do you have or ever had any of the following?	☐	☐

☐ Bacterial Endocarditis	☐ Diabetes	☐ Hepatitis A, B, C	☐ Stomach/Intestinal Problems
☐ Heart Murmur/ Valve Prolapse	☐ Hyper / Hypo Glycemia	☐ Liver Disease	☐ Glaucoma
☐ Heart Valve Replacement	☐ Thyroid Disease	☐ Jaundice	☐ Herpes
☐ Heart attack	☐ Cancer / Chemotherapy	☐ Drug / Alcohol Dependency	☐ Cold sores
☐ High / Low Blood Pressure	☐ Lung Disease (COPD, Asthma)	☐ Tuberculosis	☐ Sinus Trouble
☐ Stroke	☐ Emphysema	☐ Kidney Problems	☐ Mental or Nervous Disorder
☐ Epilepsy or Seizures	☐ Arthritis or Rheumatism	☐ Venereal Disease	☐ Malignant Hyperthermia
☐ Cortisone / Steroid Therapy	☐ Scarlet or Rheumatic Fever	☐ Other:	

	YES	NO
17. Have you had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐
18. Do you have any condition, disease or problem that you think the doctor should know about?	☐	☐
19. WOMEN ONLY: Are you pregnant or suspect you might be? If so, what month are you in?	☐	☐
Are you taking birth control pills?	☐	☐

DENTAL HISTORY **Please check YES or NO to each question**	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?	☐	☐
2. How frequent do you see your dentist? ☐ 6 Months ☐ Yearly ☐ Other:		
Previous Dentist: . . . . Last dental visit:		
Last cleaning: . . . . Last x-rays:		
3. How often do you brush your teeth? Floss? Do you have bad breath? . .	☐	☐
4. Do your gums bleed easily?	☐	☐
5. Are your teeth sensitive to: ☐Hot ☐ Cold ☐ Biting ☐ Sweets?	☐	☐
6. Do you smoke or use any other form of tobacco? Specify type and how much / many per day:	☐	☐
7. Have you ever had jaw or jaw joint surgery?	☐	☐
8. Do you have pain in your jaw joints or suffer from migraine headaches?	☐	☐
9. Does your jaw crack or pop when opened widely?	☐	☐
10. Does any part of your mouth hurt when clenched?	☐	☐
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. Have you ever experienced any growths or sore spots in your mouth? If so, where?	☐	☐
14. Previous problems with dental treatment?	☐	☐
15. Are you satisfied with the appearance of your teeth?	☐	☐
16. Please list any other dental concerns or questions:		

Office policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment please notify us 48 hours in advance in which case no charge will be made.

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 agree to have photos taken during procedures that will be used for educational purposes. I understand and agree to have photos posted on media such as web site provided full anonymity is ensured. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

. . . .
(Signature) ☐ Patient ☐ Parent ☐ Guardian

. . . .
Reviewing Dentist

Please print name: . . . .

Date: . . . .