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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

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: ______________________________ ______________________________	☐	☐	☐
> Has there been any change in your general health in the past year?	☐	☐	☐
> Are you taking any medications or non-prescription drugs of any kind? *If yes, please write their names below:* ______________________________ ______________________________	☐	☐	☐
> Do you have any allergies? *If yes, please list them below:* ______________________________	☐	☐	☐
> Have you ever had a peculiar reaction or adverse reaction to any medicines or injections? (e.g. penicillin, aspirin, or local anaesthetics, dental freezing?) *If yes, please describe:* ______________________________	☐	☐	☐
> Have you or any relatives had an unexplained or serious complication during surgery or anaesthesia? *If yes, please describe:* ______________________________	☐	☐	☐
> Do you have any heart or blood pressure problems?	☐	☐	☐
> Have you ever had rheumatic fever?	☐	☐	☐
> Do you have, or have you ever had jaundice, hepatitis, or liver disease?	☐	☐	☐
> Have you ever been told that you should not give blood?	☐	☐	☐
> Do you have any conditions that could affect your immune system, e.g. AIDS, HIV positive, leukaemia, etc	☐	☐	☐
> Do you tend to bruise easily, or do you bleed for a prolonged period of time after being cut?	☐	☐	☐
> Have you ever been hospitalised for any serious illnesses or operations?	☐	☐	☐

> Do you have, or have you ever had, any of the following? *Please tick off only those that apply:*

☐ chest pain	☐ bronchitis	☐ tuberculosis	☐ arthritis	☐ heart attack	☐ COPD
☐ epilepsy	☐ diabetes	☐ stroke	☐ asthma	☐ stomach ulcer	☐ kidney disease
☐ prosthetic joint	☐ drug/alcohol dependency		☐ Irradiation to the jaws for cancer		

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** *If yes to smoking, how many* ***cigs/day****?* _____ *For how* ***many years?*** _____

Do you smoke or eat marijuana? ☐ **Yes** ☐ **No** *If yes to marijuana, how many times/day?*

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

Follow up information to above questions: ______________________________

____

____

Height (in inches): ____________ and 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)**