PATIENT MEDICAL ALERT

Chart # _____

Name of Patient: Mr / Miss / Mrs / Ms _____
Last Name First Name

Name of Parent (If Child Patient): _____

Home Phone: _____ Work Phone: _____ Ext.: _____

Cell Phone: _____

Address: _____ Postal Code: _____

Employer: _____ Occupation: _____

Date of Birth (MM/DD/YY): _____ SIN #: _____

Person Responsible for Account: _____

Former Dentist: _____ Referred By: _____

Employer:	Employer:
Policy Holder: _____ DOB_____	Policy Holder: _____ DOB_____
Insurance Company:	Insurance Company:
Grp. #_____ Div. # _____ Cert. #_____	Grp. #_____ Div. # _____ Cert. #_____
CDA Net ☐Yes ☐ No Accept Assignment ☐Yes ☐ No	CDA Net ☐Yes ☐ No Accept Assignment ☐Yes ☐ No
Employer Auth. ☐Yes ☐ No Deduct _____Year_____	Employer Auth. ☐Yes ☐ No Deduct _____Year_____
B _____ % MX _____ Recall _____ A _____ K	B _____ % MX._____ Recall _____ A _____ K
P _____ % MX _____ Scaling _____	P _____ % MX _____ Scaling _____
M _____ % MX _____ Comp/molar _____	M _____ % MX _____ Comp/molar _____
O_____ % MX _____ P/R & Sealants _____	O_____ % MX _____ P/R & Sealants _____
Benefit-Yr. _____ Age Restrictions _____	Benefit-Yr. _____ Age Restrictions _____
_____ Flouride _____ A ____ K	_____ Flouride _____ A ____ K

Personal Physician_____ Phone_____

MEDICAL HISTORY

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

	Yes	No
1. Are you presently under a physician's care?	☐	☐
2. Do you use any medicine or drugs regularly? If so what_____	☐	☐
Do you use any recreational drugs?_____	☐	☐
3. Have you ever had any serious illness or operations? If so what_____	☐	☐
4. Have you ever been Diaganosed with or treated for Cancer?	☐	☐
5. Have you had any joint replacements?_____	☐	☐
6. Have you ever had Hepatitis?	☐	☐
7. Have you ever tested HIV Positive?	☐	☐
8. Do you smoke? How much_____	☐	☐
9. Have you had any of the following diseases? (PLEASE CIRCLE) Jaundice Diabetes High Blood Pressure Venereal Disease Tuberculosis Lung Disease Heart Disease Liver Disease Herpes Stroke Epilepsy Thyroid Disease Heart Mummur Mental and Nervous Disorders Arthritis Blood Disorders	☐	☐
10. Do you have any allergies?_____	☐	☐
11. Have you ever had Asthma or Hay Fever?	☐	☐
12. Do you commonly have Hives or Skin Rash?	☐	☐
13. Women -- Are you pregnant? Expected Delivery Date_____	☐	☐
14. Have you experienced any unusual reaction to any of the following drugs? (PLEASE CIRCLE) Aspirin Penicillin Iodine Barbiturates(Sleeping Pills) Clindamycin Codeine Any other drugs?_____	☐	☐
15. Do you bruise easily or bleed abnormally?	☐	☐
16. Do you have pain in the chest upon exertion?	☐	☐
Are you short of breath after mild exertion?	☐	☐
Do your ankles swell?	☐	☐
17. Do you experience? (PLEASE CIRCLE) Headaches Popping or Clicking in Jaw Joints Earaches Neck Pain	☐	☐
18. Have you ever experienced any unusual reaction to a Local Anaesthetic (Freezing) or Latex_____	☐	☐
19. Do you have any disease, condition or problem not listed above?	☐	☐

20. What is your estimate of your general health?
Good Fair Poor
21. What dental conditions concern you at present_____
22. Have you ever had any serious trouble associated with any previous dental experience?

_____
Emergency Contact_____ Phone_____

PAYMENT FOR PROFESSIONAL SERVICE IS REQUIRED WHEN TREATMENT IS RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE

SIGNATURE:_____ DATE_____