Mr./Mrs./Ms/Miss/Dr.
Name: _____
Date Of Birth: _____
Day / Month / Year
Address (home): _____
_____
_____
Phone: _____
Address (work): _____
_____
_____
Phone: _____
Occupation: _____
Employer/Union: _____
Dental Insurance: _____

Emergency Contact
Name: _____
Relationship: _____
Daytime Phone: _____

Family Doctor
Name: _____
Phone: _____

Medical Specialist(s)
Name: _____
Specialty: _____
Phone: _____
Name: _____
Specialty: _____
Phone: _____

PATIENT CONSENT

I have reviewed the document "PATIENT CONSENT FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION" that explains how your office will use my personal information and the steps your office is taking to protect my information. I know that your office has a Privacy Code and I can ask to see the code at any time.

I agree that **The Maples Dental Clinic** can collect, use and disclose personal information about _____ as set out above in the information about the office's privacy policies.

_____ signature

_____ print name

_____ date

_____ signature of witness

MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Y N Are you being treated for any medical condition at the present or have you been treated within the past year? If yes, please explain. _____
_____
_____

When was your last MEDICAL checkup? _____

Y N Has there been any change in your general health in the past year? If yes, please explain.
_____

Y N Are you taking any medications, non-prescription medications or herbal supplements? If yes, please list. _____
_____
_____

MEDICAL HISTORY continued

Y N Do you have any allergies? If yes, please list.

a. medications: _____

b. latex/rubber products _____

c. other (eg. hayfever, foods) _____

Y N Have you ever had a peculiar or adverse reaction to any medicine or injection? If yes, please explain. _____

_____

Y N Have you ever been treated for osteoporosis (low bone density)?

Y N Do you have or have you ever had asthma?

Y N Do you have or have you ever had any heart or blood pressure problems?

Y N Do you have or have you ever had a heart murmur, mitral valve prolapse, rheumatic fever or congenital heart defect?

Y N Do you have a prosthetic or artificial joint?

Y N Have you ever been advised by a doctor to take a dose of antibiotics before dental treatment?

Y N DO you have any conditions or undergone any therapies that could affect your immune system (eg. Leukemia, AIDS/HIV infection, radiation treatment, chemotherapy)?

Y N Have you ever had hepatitis, jaundice or liver disease?

Y N Do you have a bleeding problem or bleeding disorder?

Y N Are you hard of hearing?

Y N Have you ever been hospitalized for an illness or operation? If yes, please explain.

_____

Do you have or have you ever had any of the following? Please circle all that apply.

Chest pain/ angina	Heart attack	Stroke	Shortness of breath	Prosthetic heart valve	Pacemaker
Lung disease	Tuberculosis	Cancer	Steroid therapy	Diabetes	Stomach ulcers
Kidney disease	Thyroid disease	Seizures/ Epilepsy	Arthritis	Diet pill therapy	Drug/alcohol dependency

Y N Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.

_____

_____

Y N Are there any diseases or medical problems that run in your family (eg. diabetes, cancer, heart disease)?

Y N Do you smoke or chew tobacco? If yes,____per day for ____ years. Quit ____ years ago

Y N Are you nervous during dental treatment? If yes, about what? _____

Y N **Women only:** Are you pregnant? Due date: _____

Y N Are you breastfeeding?

To the best of my knowledge, the above information is correct.

_____ _____

Patient/Parent/Guardian Signature Dentist Signature

_____ _____

Date Date