

Confidential Medical Form

Personal Information

Last name: First name: Sex: ☐ F ☐ M

Address: City: Postal code:

Home telephone No: Work telephone No: Ext:

Cell: E-mail: Birth date (MM/DD/YYYY):

Medicare Card No: Expiry: Year: Month:

Social Insurance No. (optional):

If you are less than 18 y-o, indicate name of parent/guardian: Parent or Guardian

In case of emergency call:

Reason for visit: Referred by:

Medical History

Weight: Height: Are you currently under the care of a physician? ☐ yes ☐ no

If so, reason:

Physician's name: Physician's Telephone No:

Are you currently taking or have you taken any medication in the last six months? ☐ yes ☐ no

If yes, please describe them:

Are you presently taking natural or homeopathic products? ☐ yes ☐ no Specify:

Are you taking birth control pills? ☐ yes ☐ no Hormones? ☐ yes ☐ no Specify:

Did you have a weight loss or gain lately? ☐ yes ☐ no

Are you pregnant? ☐ yes ☐ no Are you breastfeeding? ☐ yes ☐ no

Do you or have you ever had any of the following:

Heart disease	☐ yes ☐ no	Rheumatic fever	☐ yes ☐ no
Hemophilia	☐ yes ☐ no	Prolonged bleeding	☐ yes ☐ no
Clear blood	☐ yes ☐ no	Anemia	☐ yes ☐ no
Other blood problems?			
High or low blood pressure:	☐ Normal ☐ Low ☐ High		
Frequent colds or sinusitis	☐ yes ☐ no	Tuberculosis or lung problems	☐ yes ☐ no
Digestive problems	☐ yes ☐ no	Specify the digestive problem:	
Stomach ulcers	☐ yes ☐ no	Liver problems (hepatitis A, B, C or cirrhosis)	☐ yes ☐ no
Kidney problems	☐ yes ☐ no	Do you urinate often?	☐ yes ☐ no
Sexually transmitted infections	☐ yes ☐ no	Diabetes	☐ yes ☐ no
Thyroid problems	☐ yes ☐ no	Skin disease	☐ yes ☐ no
Vision problems	☐ yes ☐ no	Arthritis	☐ yes ☐ no
Osteoporosis	☐ yes ☐ no	Do you take biphosphonates?	☐ yes ☐ no
Epilepsy	☐ yes ☐ no	Nerve problems	☐ yes ☐ no
Mental illness	☐ yes ☐ no	Specify the illness:	
Frequent headaches	☐ yes ☐ no	Dizziness or fainting	☐ yes ☐ no

Earaches	yes	no	Hay fever	yes	no
Asthma	yes	no	Do you smoke?	yes	no
Have you ever had radiation treatments or chemotherapy?	yes	no	Do you have AIDS?	yes	no
Have you tested positive for AIDS?	yes	no	Do you have any artificial joints?	yes	no
Do you snore or have you ever been told that you snore?	yes	no			

Have you ever had an allergic reaction to any of the following:

Foods	yes	no	Latex	yes	no	Penicillin	yes	no
Aspirin	yes	no	Iodine	yes	no	Sulpha drugs	yes	no
Codeine	yes	no	Local anesthetic	yes	no	Other antibiotics	yes	no

Other products, please specify:

Do you use drugs? yes no

Do you drink alcohol? No/A little In Moderation A lot

Have you ever been hospitalized or had surgery other than dental? yes no

If yes, specify the type of surgery and when?

Do you fear dental treatments? yes no

Do you wish to discuss your health privately with your dentist? yes no

Comments:

Dental History

Date of last dental visit: 0-6 months 6-12 months + than 12 months

Treatment received:

Have you had any of the following dental treatments or services?

Oral hygiene demonstration	yes	no	Gum treatment	yes	no
Orthodontic treatment (braces)	yes	no	Root canal treatment	yes	no
Fillings	yes	no	Crown(s) or bridge(s)	yes	no
Full or partial dentures	yes	no	Dental surgery or extraction	yes	no
Dental implants	yes	no	Dental X-rays	yes	no
Others	yes	no			

For professional use only:

RESERVED FOR DENTIST’S USE

I acknowledge that I have read the answers in the registration questionnaire and that I have taken the customary measures, as applicable.

Signature: _____ Date: _____

I, the undersigned, hereby declare that I have read, understood, informed myself about and answered the medical-dental questionnaire to the best of my knowledge. I hereby promise to inform you of any change in the state of my health. I authorize the creation of my dental chart, its follow-up, as well as my registration on the recall list of the attending dentist(s). I have been informed that my chart will be kept in the office at all times and that only the dentist(s) and his/her (their) support staff will have access to it. I have also been informed of my right to consult my chart, to request that it be corrected and to remove my name from the recall list.

Signature: _____ Date: _____