Date: _____

Owen Sound Dental Clinic
WELCOME TO OUR OFFICE
REGISTRATION INFORMATION

Medical Alert	

Please answer the questions as accurately as you can. If you have any questions or doubts, please ask the treating dentist or our receptionist, who is available to assist you with the completion of this form. All information is **strictly confidential** and will remain with this office. **PLEASE PRINT.**

The patient is an: ADULT ☐ CHILD ☐ ADULT UNDER GUARDIANSHIP ☐

Name of Guardian: _____

Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Referred by: _____

Name: _____ _____ Birth Date: M ___ D ___ Y ___
(last) (first) (initial) (prefers to be called)

Address: _____ _____ _____ Home Phone: ( ) _____
(street) (apt#) (city) (postal code) Bus. Phone: ( ) _____

Age ___ Sex ___ Marital Status ___ May we call you at work? Yes ☐ No ☐ Employer: _____

Person responsible for account: _____ Name of spouse: _____

Do you have insurance? Yes ☐ No ☐ Insurance Co. _____ Policy No. _____ Cert. No. _____

(name) (address) Health Card # _____

Family Physician: _____ Phone: ( ) _____

Are you under the care of a Medical Specialist? Yes ☐ No ☐ _____ Phone: ( ) _____

In case of emergency, please contact: _____ Phone: ( ) _____

1. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

_____

_____

_____

2. When was your last medical checkup? _____

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

_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

4. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? _____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:

☐ YES ☐ NO ☐ NOT SURE/MAYBE

a) medications _____
b) latex/rubber products _____
c) other, e.g. hayfever, foods _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

7. Do you have a disability? Explain below. ☐ YES ☐ NO

_____

8. Do you have or have you ever had a heart murmur, mitral valve prolapse, or rheumatic fever?

☐ YES ☐ NO ☐ NOT SURE/MAYBE

9. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

10. Have you ever been advised by your doctor to take antibiotics before dental treatment?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice, or liver disease?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder?
☐ YES ☐ NO ☐ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

_____

_____

15. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ shortness of breath	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)	☐ drug/alcohol dependency
☐ heart attack		☐ lung disease	☐ diabetes	☐ kidney disease	
☐ stroke	☐ prosthetic heart valve	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	
☐ blood pressure problem	☐ asthma	☐ cancer	☐ arthritis	☐ diet pill therapy	

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

_____

17. Are there any diseases or medical problems that run in your family?
(e.g. diabetes, cancer, or heart disease) ☐ YES ☐ NO ☐ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

19. Are you nervous during dental treatment? ☐ YES ☐ NO ☐ NOT SURE/MAYBE

20. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
_____ ☐ YES ☐ NO ☐ NOT SURE/MAYBE

(Complete both sides before signing) **GENERAL 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 as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____ _____

PATIENT ☐ PARENT ☐ GUARDIAN ☐ (PRINT NAME OF GUARDIAN)