Welcome to Summit Heights Dental

HEALTH HISTORY & REGISTRATION

The patient is an: Adult ☐ Child ☐ Adult under Guardianship ☐
Name of Guardian _____
PATIENT NAME: Last: _____ First: _____ Middle Initial _____
Prefers to be Called _____
BIRTHDATE: M____ D____ Y_____ AGE: _____ SEX: M ☐ F ☐
ADDRESS: _____ APT#: ____ CITY: _____
PROVINCE: _____ POSTAL CODE: _____ HOME PHONE:_____
CELL PHONE: _____ WORK PHONE: _____ EMAIL: _____
EMPLOYER: _____ OCCUPATION: _____ May we contact you at work? ☐
TODAY'S DATE:_____
Who May We Thank for Referring You to our Office? _____
Reason for this Visit: Examination ☐ Emergency ☐ Other ☐
Family Physician: _____ PHONE: _____
Medical Specialist: _____ PHONE: _____
Emergency Contact: _____ PHONE: _____

FINANCIAL INFORMATION

Person Responsible for Account: Self ☐ Spouse ☐ Other ☐
Please complete all information if different from above
NAME: Last: _____ First: _____ Middle Initial: _____
ADDRESS: _____ APT#: ____ CITY: _____
PROVINCE: _____ POSTAL CODE: _____ HOME PHONE:_____
CELL PHONE: _____ WORK PHONE: _____ EMAIL: _____
CREDIT CARD: MC ☐ Visa ☐ Number: _____ Expiry Date: _____
Signature: _____
This signature authorizes payment of my account on the above card

PRIMARY DENTAL INSURANCE

Insured Name: _____
D.O.B. M____ D____ Y_____
Insurance Co: _____
Insured Employer: _____
Group # _____ Cert # _____

SECONDARY DENTAL INSURANCE

Insured Name: _____
D.O.B. M____ D____ Y_____
Insurance Co: _____
Insured Employer: _____
Group # _____ Cert # _____

It is important that we know about your Medical / Dental history. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone.
Thank you for taking the time to fill out this questionnaire.

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MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS? Yes ☐ No ☐

If yes, are you under a PHYSICIAN'S CARE now? Yes ☐ No ☐

For what? _____

What MEDICATIONS are you currently taking?

_____

_____

Are you PREGNANT? Yes ☐ No ☐ DUE DATE? _____

Do you use cigars / cigarettes / pipe / chewing tobacco? (circle)

Indicate which of the following you presently have, or have ever had: (Please check all that apply)

- ☐ AIDS / HIV Pos
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis (Rheumatism)
- ☐ Artificial Heart Valves
- ☐ Artificial Joints (Hip / Knee / Other)
- ☐ Asthma
- ☐ Allergies
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependancy
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough (persistent)
- ☐ Coughing up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmer
- ☐ Heart Problems (please describe)

  _____
- ☐ Hemophilia (abnormal bleeding)
- ☐ Herpes
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse (MVP)
- ☐ Nerve Problems
- ☐ Pacemaker / Heart Surgery
- ☐ Psychiatric Care
- ☐ Rapid Weight gain / loss
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic / Scarlet Fever
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Surgical Implant
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Disease or Malfunction
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer / Colitis
- ☐ Venereal Disease

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

☐ Aspirin ☐ Local Anaesthetic ☐ Erythromycin ☐ Latex ☐ Nitrous Oxide ☐ Codeine ☐ Penicillin

Are you aware of being allergic to any other medications or substances?

_____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete 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. **Should there be any changes in my health status in the future, I will advise the dental office.** 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 consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependants is mine, and I assume responsibility for fees associated with these services.

SIGNATURE: Patient ☐ Parent ☐ Guardian ☐

_____ DATE: _____

TREATING DENTIST'S SIGNATURE: _____ DATE: _____