Confidential Medical Form

Personal Information

Last name:		First nan	ne:		:	Sex:	F	М	
Address:		City:			Postal code:				
Home telephone No:	Work telephone No:				Ext:				
Cell:	E-mail:			Birth date (MM/DI	D/YYYY):				
Medicare Card No:		E	xpiry: Year:	Montl	n:				
Social Insurance No. (optional):									
If you are less than 18 y-o, indic	cate name of parent/	guardian:			Par	ent or	Guard	dian	
In case of emergency call:									
Reason for visit:			Re	ferred by:					
Medical History				· · · · · · · · · · · · · · · · · · ·					
Weight:	Height:		Are you c	urrently under the o	are of a nhysicia	an?	yes	no	
C	rieigitt.		rue you e	arrently ander the c	are or a priyation		yes	110	
If so, reason:		51							
Physician's name:				lephone No:					
Are you currently taking or have	e you taken any medi	cation in th	e iast six mo	onths? yes	no				
If yes, please describe them:									
Are you presently taking natural	or homeopathic prod	ducts?	yes r	no Specify:					
Are you taking birth control pills	? yes no	Hormone	s? yes	no Specify:					
Did you have a weight loss or g		no							
Are you pregnant? yes	no Are you brea	_	yes	no					
Do you or have you ever had	d any of the followi			Dhoumatia fovor					
Heart disease Hemophilia		yes	no	Rheumatic fever Prolonged bleeding	,			yes	no
Clear blood		yes	no	Anemia	d			yes	no
Other blood problems?		yes	no	Ancinia				yes	no
High or low blood pressure:		Name al	1	115-4-					
Frequent colds or sinusitis		Normal	Low	High Tuberculosis or lur	na problems			V00	no
Digestive problems		yes	no					yes	no
Stomach ulcers		yes	no	Specify the digesting Liver problems (he	•	r cirrhos	cis)	V06	no
Kidney problems		yes	no	Do you urinate offe	•	0111103	,,,,,	yes	no
Sexually transmitted infections		yes yes	no	Diabetes	····			yes	no no
Thyroid problems		yes	no	Skin disease				yes	no
Vision problems		yes	no	Arthritis				yes	no
Osteoporosis		yes	no	Do you take bipho	sphonates?			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

Asthma yes no Do you smoke? yes no sometimely a complete the positive for ALDS? yes no Do you have ALDS? yes no Do you have any artificial joints? yes no Do you was any artificial joints? yes no Do you have any artificial joints? yes no Do you have any artificial joints? yes no Do you was any artificial joints?									
Have you ever had radiation treatments or yes no Do you have AIDS? yes no Do you have any artificial joints? yes no Dental Have you ever had an allergic reaction to any of the following: Todds yes no Latex yes no Penicillin yes no Other antibiotics	Earaches	yes	no	Hay fever				yes	n
themotherapy? yes no Do you have any artificial joints? yes no Penicillin yes no Aspirin yes no Sulpha drugs yes no Sulpha drugs yes no Do you use drugs? yes no Uccal anesthetic yes no Other antibiotics yes no Do you use drugs? yes no Do you drik alcohol? No/A little In Moderation A lot Have you ever been hospitalized or had surgery other than dental? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your de	Asthma	yes	no	Do you sm	oke?	yes	no	sor	netime
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 Sulpha drugs 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 Yes yes no Yes you fear dental treatments? Yes no Do you wish to discuss your health privetaly 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? Drail hyglene demonstration Yes no Gum treatment Yes no Porthodontic treatment (braces) Yes no Root canal treatment Yes no Crown(s) or bridge(s) Yes no Dental surgery or extraction Yes no Dental implants Yes no Dental X-rays Yes no Dothers Yes no Others Yes no Dental X-rays Yes no Dental Y-rays Yes no Dental Inplants Yes no Dental Inplants Yes no Dental X-rays Yes no Dental Y-rays Yes	Have you ever had radiation treatments or chemotherapy?	yes	no	Do you hav	Do you have AIDS?			yes	n
Have you ever had an allergic reaction to any of the following: Foods yes no Latex yes no Penicillin yes no Sulpha drugs yes no Sulpha drugs yes no Sulpha drugs yes no Other antibiotics yes no Other antibiotics 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 Do you drink alcohol? No/A little In Moderation A lot Have you ever been hospitalized or had surgery other than dental? 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 Do you drink alcohol? No/A little In Moderation A lot Have you ever been hospitalized or had surgery other than dental? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your h	Have you tested positive for AIDS?	yes	no	Do you hav	e any ar	tificial joints?		yes	n
Aspirin yes no latex yes no Penicillin yes no Penicillin yes no Aspirin yes no Iodine yes no Sulpha drugs yes no Codeine yes n	Do you snore or have you ever been told that	you snore?	yes	no					
Aspirin yes no lodine yes no Sulpha drugs yes no Other antibiotics yes no Other products, please specify: Do you use drugs? yes no Do you use drugs? yes no 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 wish to discuss your health privetally with your dentist? yes no Do you wish to discuss your health privetally with your dentist? yes no Do you wish to discuss your health privetally with your dentist? yes no Do you had any of the following dental treatments or services? Doral hygiene demonstration yes no Gum treatment yes no Dorthodontic treatment (braces) yes no Root canal treatment yes no Dorthodontic treatment (braces) yes no Dental Surgery or extraction yes no Dental Inplants yes no Dental Surgery or extraction yes no Dortholontic Inplants yes no Dental Surgery or extraction yes no Dortholontic yes no Dortholontic yes no Dental Surgery or extraction yes no Dortholontic yes no Dental Inplants yes no Dental Surgery or extraction yes no Dortholontic yes no Dortholontic yes no Dental Surgery or extraction yes no Dortholontic yes no Dental Surgery or extraction yes no Dortholontic yes no Dental Surgery or extraction yes no Dortholontic yes no Dental Surgery or extraction yes no Dortholontic yes no Dental Surgery or extraction yes no Dental Surgery Dental Manual Surgery Dental Surgery	Have you ever had an allergic reaction to	o any of the f	ollowing:						
Odeline 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 Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly yes no Do you wish to discuss your health privetaly yes no Do you wish to discuss your health privetaly yes no Do you wish to discuss your health privetaly yes no Do you wish to discuss your health privetaly yes no Do you wish to discuss your health privetaly yes no Do you wish t	Foods yes no	Latex		yes	no	Penicillin		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 Do you fear dental treatments? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Do you wish to discuss your health privetaly with your dentist? yes no Donatal History Date of last dental visit: 0-6 months 6-12 months + than 12 months Freatment received: Have you had any of the following dental treatments or services? Doral hygiene demonstration yes no Dorthodontic treatment (braces) yes no Gum treatment yes no Dorthodontic treatment (braces) yes no Dental surgery or extraction yes no Dorthodontic treatment yes no Donatal implants yes no Dental X-rays yes no Dotters yes no	Aspirin yes no	Iodine		yes	no	Sulpha drugs		yes	no
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 privetaly 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? Draid 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 Dental surgery or extraction yes no Dental implants yes no Dental X-rays yes no Dental implants yes no Dental implants yes no Dental X-rays yes no Dental X-rays yes no	Codeine yes no	Local anes	thetic	yes	no	Other antibiotics		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 lif yes, specify the type of surgery and when? Do you fear dental treatments? yes no Do you wish to discuss your health privetaly 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? Dral hygiene demonstration yes no Gum treatment yes no Orthodontic treatment (braces) yes no Root canal treatment yes no Fillings yes no Dental surgery or extraction yes no Dental implants yes no Dental X-rays yes no Dental implants yes no Dental implants yes no Dental implants yes no Dental X-rays yes no	Other products, please specify:								
Have you ever been hospitalized or had surgery other than dental? If yes, specify the type of surgery and when? Do you fear dental treatments? Do you wish to discuss your health privetaly with your dentist? Dental History Date of last dental visit: O-6 months 6-12 months + than 12 months Treatment received: Have you had any of the following dental treatments or services? Doral hygiene demonstration yes no Gum treatment yes no Orthodontic treatment (braces) yes no Crown(s) or bridge(s) yes no Dental surgery or extraction yes no Dental implants yes no Dental X-rays yes no Dental X-rays yes no Dental yes no Dental X-rays	Do you use drugs? yes no								
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Do you fear dental treatments? yes no Do you wish to discuss your health privetaly 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? Dral hygiene demonstration yes no Gum treatment yes no Orthodontic treatment (braces) yes no Root canal treatment yes no Fillings yes no Dental surgery or extraction yes no Dental implants yes no Dental X-rays yes no Others yes no Dental X-rays yes no Others	Have you ever been hospitalized or had surge	ery other than o	dental?	yes no					
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Full or partial dentures yes no Dental surgery or extraction yes no Dental X-rays yes no Others yes no	Orthodontic treatment (braces)	yes	no	Root canal trea	atment		yes	no)
Dental implants yes no Dental X-rays yes no Others yes no	Fillings	yes	no	Crown(s) or br	idge(s)		yes	no)
Others yes no	Full or partial dentures	yes	no	Dental surgery	or extra	ction	yes	no)
yes no	Dental implants	yes	no	Dental X-rays			yes	no)
For professional use only:	Others	yes	no						
	For professional use only:								
	RESERVED FOR DENTIST'S USE								
RESERVED FOR DENTIST'S USE		e registration que	estionnaire	and that I have tak	en the cus	stomary measures, as applic	cable.		
RESERVED FOR DENTIST'S USE	· ·								
acknowledge that I have read the answers in the registration questionnaire and that I have taken the customary measures, as applicable.	I, the undersigned, hereby declare that I have rea knowledge. I hereby promise to inform you of any registration on the recall list of the attending denti and his/her (their) support staff will have access to	d, understood, i change in the s ist(s). I have bee	nformed my state of my en informed	yself about and anso health. I authorize t I that my chart will I	wered the the creation be kept in	medical-dental questionnal on of my dental chart, its fo the office at all times and t	llow-up, that only	as well as the dent	s my ist(s)
Date:									
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)									