ETOBICOKE DENTAL
Health Centre

PERSONAL HISTORY:

Patient Last Name: _____ Patient First Name: _____
Patient Date of Birth: _____ Address: _____
_____
Home Telephone: _____ Work #: _____
Cell #: _____ Email: _____

Dental Insurance: YES NO (Circle One)

Emergency Contact: _____ Contact #: _____

HEALTH HISTORY:

Please answer **YES or **No** to each question below. If Unsure please ask for assistance.

1. Are you being treated for any medical conditions presently or within the past 2 years? YES / NO
   If Yes Please explain: _____
2. When was your last complete physical Examination? _____
3. Are you currently taking **ANY** prescription or NON-Prescription drugs? If YES Please list:
   _____
4. Have you ever adversely reacted to any of the following? **Please Circle**
   PENICILLIN SULFA ASPIRIN BARBITURATES CODEINE DARVON LOCAL ANAESTHETIC
   NITROUS OXIDE ~ Or list any other medications: _____
5. Have you ever been advised against taking any other kind of medication? **YES / NO**
   If YES please list: _____
6. Do you have any of the following Conditions? **Please Circle** HIVES ASTHMA HAY FEVER
   FOOD ALLERGIES METAL ALLERGIES LATEX ALLERGIES SKIN RASHES or ANY OTHER
   ALLERGIES: **(Please List below)**
   _____
   _____
7. Do you smoke? YES / NO Do you wear the transdermal nicotine patch? YES / NO
8. Are you Alcohol or Drug dependent? YES / NO

9. Please review the lists below and circle **ANY** and **ALL** that apply to you **(Past or Present**)

AIDS	HEAD/NECK INJURIES	SINUS TROUBLES
ABNORMAL PAP SMEAR	HEART ATTACK	HPV
ANEMIA	HEART DISEASE	HYPERGLYCEMIA
ARTHRITIS/RHEUMATISM	HEPATITIS A	JAUNDICE
ARTIFICIAL JOINTS	HEPATITIS B	KIDNEY DISEASE
BLOOD DISORDERS	HEPATITIS C	LIVER DISEASE
BRONCHITIS	HODGKINS DISEASE	LUNG DISEASE
CANCER	PACEMAKER	MALIGNANT HYPERTHERMIA
CONSTANT COUGH	PARKINSONS	ORGAN TRANSPLANT/IMPLANT
DIABETES	MULTIPLE SCLEROSIS	THYROID DISEASE
EPILEPSY/SEIZURES	STROKE	PSYCHIATRIC TREATMENT
FAINTING/DIZZY SPELLS	PARKINSONS	SICKLE CELL DISEASE
GLAUCOMA	RADIATION TREATMENT	STOMACH/INTESTINAL PROBLEMS
HERPES	TUBERCULOSIS	RHEUMATIC/SCARLET FEVER
HIGH BLOOD PRESSURE	ULCERS	SINUS TROUBLES
HYPERTENSION	MITRAL VALVE PROLAPSE	

OTHER:

_____

_____

Women ONLY:

1. Are you pregnant or suspect you may be? YES / NO ~ If YES how far along? _____
2. Are you taking birth control pills? YES / NO
3. Is there anything further about your health (not listed) we should be made aware of? YES/NO
   If YES please list: _____

4. Do you wish to speak with the Doctor privately about a matter? YES / NO

Dental History:

** Please circle YES or No for each question below

1. Have you been seeing a dentist regularly? YES / NO
2. Have you ever had any of the following?
   Periodontal Disease- YES / NO
   Orthodontic Treatment – YES / NO
   Bite plate/other appliance – YES / NO
   Oral Surgery- YES / NO
3. Do you grind or clench your teeth? YES / NO
4. Do you have any growths or sore spots in your mouth? YES / NO
5. Do your gums bleed when you brush or eat? YES / NO

6. Do you have any loose teeth or any teeth that have shifted? YES / NO
7. Do you have any sensitivity to **HOT or COLD** anywhere in your mouth? YES / NO
8. Have you ever been advised to take antibiotics before any dental treatment? YES / NO
9. Do you floss your teeth? YES / NO how often? _____

10. Have you ever experienced any of the following? (Please circle)
    POPPING/CLICKING OF THE JAW PAIN IN JAW PAIN IN EAR DIFFICULTY OPENING
    DIFFICULTY CLOSING PAIN WHEN CHEWING PAIN WHEN TEETH ARE CLENCHED

11. Do you have any emotional concerns about dental treatment? YES / NO
12. Are you happy with the appearance of your teeth? YES / NO
    If NO please explain _____

13. Have you ever had an upsetting experience at a dental office? YES / NO
14. Is there any dental problem that you would like to see dressed immediately? YES / NO

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 regarding my medical-dental history. Should there be any change in my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. 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.

Governing Law

The patient agrees that the relationship between himself or herself and the dentist shall be governed and construed in accordance with the laws of the province of Ontario

Jurisdiction

The patient acknowledges that the treatment/services is to be performed in the province of Ontario, and agrees that the courts of the province of Ontario shall have exclusive jurisdiction to adjudicate any complaint, demand, claim or cause of action, whether based on alleged negligence arising out of the treatment. The patient hereby agrees that he or she will commence any such legal proceedings in the province of Ontario and only in the province of Ontario and hereby submits to the jurisdiction of the province.

XX _____ _____
(Signature of Patient) (Print Name of Patient/Parent/Guardian)
(If under 18 years Parent/Guardian)
Date: _____

Witness: _____ Date: _____
Reviewing Dentist: _____ Date: _____