DENTISTRY @ ROCKLAND

Medical History

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Rockland, ON, K4K 1A2
Phone: (613)446.0009
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Patient Name	**Medical Alert** (*office use only*)

Address _____ City _____ Postal Code_____

Phone (home) _____ (cell)_____ Sex: M ☐ F ☐ Age _____ Birth Date_____/_____/_____
month day year

Adult Patient

Occupation _____

Employer _____

Phone (work) _____

Email _____

Marital Status: M ☐ S ☐ W ☐ D ☐ Other_____

Dental Insurance: Yes ☐ No ☐

Child Patient

Mother's Name _____

Employer _____Phone(work)_____

Father's Name _____

Employer _____Phone(work) _____

Person responsible for account _____

Health Card # _____

How did you hear about our office? Friend ☐ / Phonebook (Yellow Pages) ☐ / Newspaper ☐ / Flyer ☐ / Internet ☐ / Website ☐ / Other ☐
Name of person or please specify_____

1.Have you been under the care of a medical doctor during the past two years? Yes ☐ No☐

If yes, for what? _____

Physician's name _____ Phone _____

2.Have you taken any medication or drugs during the past two years? Yes ☐ No ☐

3.Are you taking any medication, drugs or pills now? Yes ☐ No ☐

If yes, please list the name and dosage _____

4.Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes ☐ No ☐

If yes, please list _____

5.Have you been hospitalized in the past five years? Yes ☐ No ☐

6.Indicate which of the following you have had, or presently have:

☐ A.I.D.S.	☐ Congenital Heart Disease	☐ Heart Pacemaker	☐ Psychiatric/Psychological Care
☐ Allergies or Hives	☐ Cortisone Medicine	☐ Hemophilia	☐ Radiation Therapy
☐ Arthritis / Rheumatism	☐ Diabetes	☐ Hepatitis	☐ Rheumatic Fever
☐ Artificial Heart Valve	☐ Diet (Special / Restricted)	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Artificial Joints (hip, knee etc.)	☐ Do You Smoke	☐ H.I.V. Positive	☐ Sinus Trouble
☐ Asthma	☐ Emphysema	☐ Jaundice	☐ Stomach Ulcers
☐ Blood Transfusion	☐ Epilepsy or Seizures	☐ Kidney Trouble	☐ Stroke
☐ Bruise Easily	☐ Fainting or Dizzy Spells	☐ Latex Sensitivity	☐ Swollen Ankles
☐ Chemotherapy	☐ Glaucoma	☐ Liver Disease	☐ Tuberculosis
☐ Chest Pain	☐ Hay Fever	☐ Mitral Valve Prolapse	☐ Tumors
☐ Chronic Cough	☐ Heart (Surgery, Disease, Attack)	☐ Nervous / Anxious	☐ Thyroid Problems
☐ Cold Sores / Fever Blisters	☐ Heart Murmur	☐ Neurological Disorders	☐ Venereal Disease

7.Do you have, or have you had any disease, or problem not listed? Yes ☐ No ☐

If yes, please list _____

8.Women only Are you: **Pregnant?** Yes ☐ Months _____ No ☐ **Nursing?** Yes ☐ No ☐ **Taking birth control pills?** Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the representative health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient / Guardian Signature: _____ **Date:** _____/_____/_____
Month Day Year