WELCOME TO LIMESTONE CITY DENTAL CENTRE

In order to render optimum health service it is necessary to become acquainted with your vital information. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment, they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION. Thank you.

Today's Date ____________________
Day Month Year

PERSONAL INFORMATION

Name ____________________ Date of Birth ____________ Age ______
DD/MM/YR

Address ____________________ Sex: M ☐ F ☐

City ____________________ Phone - Home ____________________

Postal Code ____________________ Work ____________________

Occupation ____________________ Cell ____________________

In case of emergency please contact: (Name) ____________________ (Tel) ____________

Name of Employer ____________________ Are you insured? Yes ☐ No ☐

Name of person responsible for this account ____________________

Insurance Company Name ____________________

Policy No. ____________________ ID No. ____________________

When was your last dental examination? ____________________

Who referred you to our office? ____________________

MEDICAL HISTORY

Physician s Name ____________________ Telephone ____________

Date of last medical exam ____________________ B.P. ____________

	Yes	No
1. Have you ever been hospitalized or had a serious illness? . . . . If so, what/when? ____________________	☐	☐
2. Are you being treated for **any** condition by a physician? . . . . If so, what? ____________________	☐	☐
3. Are you presently taking any medication? . . . . List medication ____________________	☐	☐
4. Do you regularly take dietary supplements or herbal medicines? . . . . Please specify: ____________________	☐	☐

5. Have you ever had or been treated for: No ☐

☐ heart trouble	☐ arthritis	☐ thyroid problems
☐ heart attack	☐ bone or muscle problems	☐ bleeding problems
☐ high blood pressure	☐ ulcer	☐ anaemia
☐ tuberculosis	☐ gastrointestinal problems	☐ glaucoma
☐ persistent cough	☐ kidney problems	☐ epilepsy
☐ coughing up blood	☐ diabetes	☐ venereal disease
☐ shortness of breath	☐ liver problems	☐ skin disorder
☐ pain in chest	☐ hepatitis	☐ HIV (AIDS)
☐ osteoporosis	☐ jaundice	☐ Heart Surgery

other ____________________

	Yes	No
6. Do you ever have asthma, hayfever, hives, skin rash?	☐	☐
7. Have you ever had an **adverse reaction** to any drug including local anaesthetic? . . . . . If so, what? ____________________	☐	☐

8. Are you **allergic** to any drugs or medication? ☐ Penicillin ☐ Erythromycin — No ☐

☐ Sulpha ☐ Aspirin ☐ Codeine ☐ Tetracycline ☐ Barbituates

☐ Latex rubber Other ____________________

	Yes	No
9. Do you have any problems when cut or bruised?	☐	☐

PLEASE TURN OVER

	Yes	No
10. Have you had or are you having radiation therapy or chemotherapy?	☐	☐
11. Have you ever fainted?	☐	☐
12. Are you pregnant or nursing?	☐	☐
13. Do you smoke? If yes, how long?	☐	☐
14. Have you ever had an adverse reaction to any metals, jewelery, etc.?	☐	☐
15. Have you ever had a joint replacement?	☐	☐
16. Do you require antibiotics prior to dental treatment?	☐	☐
17. Do you or have you ever had: Artificial Heart Valve, Endocarditis or Pericarditis?	☐	☐
18. Is there anything that the dentist should know about your medical history that has not been mentioned? (explain)	☐	☐

By attending this dental office I provide consent to treatment for my oral health needs as determined by the dentist and myself.

Signature ______________________________

Medical Update

1) Date ____________________ Changes ____________________

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Patient's Signature ______________________________

2) Date ____________________ Changes ____________________

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Patient's Signature ______________________________

3) Date ____________________ Changes ____________________

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Patient's Signature ______________________________

4) Date ____________________ Changes ____________________

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Patient's Signature ______________________________

5) Date ____________________ Changes ____________________

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Patient's Signature ______________________________

6) Date ____________________ Changes ____________________

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Patient's Signature ______________________________

7) Date ____________________ Changes ____________________

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Patient's Signature ______________________________

8) Date ____________________ Changes ____________________

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Patient's Signature ______________________________

The medical history has been reviewed by the dentist and the dental hygienist may proceed with scaling.

Dentist's Signature ______________________________