

# PATIENT MEDICAL HISTORY

YES      NO

	YES	NO
1. Are you now under the care of a physician? _____ What is the condition being treated? _____		
2. Have you had any serious illness or operation? _____ If yes, what was the illness or operation? _____		
3. Are you taking any drug or medicine including birth control pills or herbal/organic supplements? _____ If yes, what? _____		
4. Do you use tobacco products? _____ Cigarettes _____ No. per day _____ Pipe _____ Snuff _____ Have you ever tried to eliminate these products from your life? _____		
5. Are you allergic to or have you reacted adversely to any drug or medicine: eg. local anaesthetic (freezing), penicillin or other antibiotics, barbituates, sedatives, analgesics (pain killers)? _____ If so, what? _____		
6. Do you have any of the following? a. Rheumatic fever or rheumatic heart disease _____ b. Birth defects in the heart _____ c. Heart attack, high blood pressure, hardening of the arteries, stroke _____ d. Chest pains or shortness of breath _____ e. Asthma, hay fever or skin rash _____ f. Fainting spells or seizures (epilepsy) _____ g. Diabetes _____ h. Kidney disease _____ i. Hepatitis, jaundice or liver disease _____ j. Thyroid disorder _____ k. Lung or breathing disorder _____ l. Stomach/bowel problems: eg. ulcers _____ m. Nervous disorder _____ n. Bone, muscle or joint disorders: eg. arthritis _____ o. Cancer _____ p. Aids or ARC HIV Positive _____		
7. Have you ever had abnormal bleeding associated with previous extractions, surgery or cuts? _____		
8. Do you have any blood disorder? _____		
9. Women, are you pregnant? _____		
10. Do you have any disease or disorder not listed that you think I should know about? If yes, what? _____		

**TREATMENT CONSENT**

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable and will assume responsibility for the fees associated with those procedures.

Signature of patient (parent, guardian) \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT PERSONAL INFORMATION

Patient Last Name: \_\_\_\_\_

Patient Mailing Address: \_\_\_\_\_

Patient First Name: \_\_\_\_\_

\_\_\_\_\_

Patient Middle Initial: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_

City: \_\_\_\_\_

Title: Mr. Mrs. Miss, Master, Ms. \_\_\_\_\_

Prov.: \_\_\_ Postal Code: \_\_\_\_\_

Marital Status: M \_\_\_ S \_\_\_ C.L. \_\_\_\_\_

If Child - Parent's Name: \_\_\_\_\_

Spouse or Partner's Name: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Res. Phone: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_

Bus. Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_

Policy Holder's S.I.N.: \_\_\_\_\_

Cell. Phone: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

S.I.N.: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Birth Date: Month \_\_\_ Day \_\_\_ Year \_\_\_\_\_

Group # \_\_\_\_\_ Dependent #: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Basic \_\_\_\_\_ Crown & Bridge \_\_\_\_\_

Who may we thank for referring you?:

Ortho \_\_\_\_\_

Person: \_\_\_\_\_

Is there a deductible? Yes \_\_\_ No \_\_\_

Yellow Pages: \_\_\_\_\_

Indian Affairs Dental Coverage

Staff: \_\_\_\_\_ Other: \_\_\_\_\_

Yes  No Status #: \_\_\_\_\_

Have you seen a dentist this year?: Yes \_\_\_ No \_\_\_

Who?: \_\_\_\_\_

Care Card #: \_\_\_\_\_

If yes, what was done? \_\_\_\_\_

Dental Concerns: \_\_\_\_\_

Are you aware of our web site? Yes \_\_\_ No \_\_\_

Have you used our web site? Yes \_\_\_ No \_\_\_

[www.vanderhoofdental.com](http://www.vanderhoofdental.com)

**NOTE: If your insurance company will not pay for a procedure the responsibility is yours. The insurance contract is between the insured patient and the insurance company, not the dentist and the insurance company.**