EMERGENCY-DENTAL-365.COM

300 York Mills Road, Unit 2b
Toronto, Ontario, M2L 2Y5
Telephone: (416) 510-2253, Fax: (416) 510-1822

CONFIDENTIAL MEDICAL HISTORY DATE_____

Name Mr. Miss Mrs. Ms _____ Name of Husband/Wife_____

Home Phone(___)_____ Business Phone(___)_____ Cell/Pager_____

Address_____ Apt #_____ City_____ Postal Code_____

Date of Birth (dd/mm/yy)_____ Age_____ Occupation _____

Physician_____ Phone# (___)_____

Dentist_____

Have you been here before?_____

Do you have dental insurance?_____

Payment method for today Visa___ Mastercard___ Amex___ Debt_____ Other____

What is your dental emergency today? _____

Yes ___No ___ Are you having pain or discomfort at this time?_____
Yes ___No ___ Do you clench or grind your teeth?_____
Yes ___No ___ Do any teeth feel loose?_____
Yes ___No ___ Do your gums bleed when brushing?_____
Yes ___No ___ Have you ever had gum treatment before?_____
Yes ___No ___ Are you allergic to any drugs or medication?_____
Yes ___No ___ Are you taking any medication presently? Please list_____
Yes ___No ___ Are you taking any herbal remedies? Please list_____
Yes ___No ___ Have you ever had any excessive bleeding?_____
Yes ___No ___ Do you smoke? If yes, how much per day?_____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Allergies	Diabetes	Hepatitis: A/B/C	Radiation Treatment
Anemia	Dizziness	High Blood Pressure	Respiratory Problems
Angina	Drug Addiction	HIV + (AIDS)	Rheumatic Fever
Arthritis	Emphysema	Hives	Rheumatism
Artificial Joint	Epilepsy	Jaundice	Sickle Cell Disease
Artificial Valve	Excessive Bleeding	Kidney Disease	Sinus Problems
Aspirin Allergy	Excessive Bruising	Liver Disease	Stomach Problems
Asthma	Fainting	Local Anaesth. Allergy	Stroke
Auto-immune Disease	Gastro-Intestinal	Low Blood Pressure	Sulpha Allergy
Barbituates Allergy	Glaucoma	Lupus	Thyroid Disease
Blood Disease	Hard to Freeze	Mental Disorders	TMJ
Cancer	Hay Fever	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Head Injuries	Multiple Sclerosis	Tumors
Codeine Allergy	Heart Disease	Nervous Disorders	Ulcers
Congenital Heart Lesions	Heart Murmur	Pacemaker	Venereal Disease
Contraceptive Use	Heart Surgery	Penicillin Allergy	
Cortisone Medication	Hemophilia	Pre-Medication	

Do you have any disease, condition or problem not listed above?_____

WOMEN: Are you pregnant or do you anticipate becoming pregnant in the near future?_____

NOTES: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

⇒_____ ⇒_____

PATIENT'S SIGNATURE **DENTIST SIGNATURE**