Periodontics Medical and Dental History Forms

Personal Information (please click on where applicable and type directly on this form before printing)

Patient's name: Mr.❑ Mrs.❑ Miss ❑ Ms.❑

_____

OHIP#_____ Drivers Lic.#_____

This is required for any narcotic analgesics (new Provincial Requirement)

Medical History

Medical Doctor's Name: _____ Telephone Number: (_____) -_____ - _____

Address: _____

My Last Physical Examination was on (Date): _____(M/D/Y)

Results:

_____

Are you being treated by a doctor now? Yes❑ No ❑

If yes, for what reason?

_____

Are you taking any medicine at the present time? Yes❑ No ❑

If yes, what?

_____

Do you take aspirin on a regular basis? Yes ❑ No ❑

If yes, how often?

_____

Are you sensitive or allergic to any medication? Yes❑ No ❑

If yes, what?

_____

Have you ever been hospitalized or had any surgical operations? Yes❑ No ❑

If yes, list reasons and dates:

_____

Have you ever had a blood transfusion? Yes❑ No ❑

If yes, give reason:

_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (please check if applicable)

❑HIV Positive/Aids

❑High blood pressure

❑Osteoporosis

❑Asthma

❑Stroke

❑Hay Fever

❑ Tuberculosis
❑ Allergies or Hives
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Arthritis
❑ Heart Murmur
❑ Heart Disease
❑ Kidney Disease
❑ Angina Pectoris
❑ Hepatitis
❑ Gall Bladder Disease
❑ Mitral Valve Prolapse
❑ Nervousness
❑ Epilepsy or Seizures
❑ Pacemaker
❑ Do you bruise easily
❑ Thyroid Disease (Goiter)
❑ Do your ankles swell
❑ Chemotherapy (Cancer, Leukemia)
❑ Low Blood Pressure
❑ Do you use extra pillows to sleep
❑ Anemia
❑ Have you ever had Yellow Jaundice
❑ Bladder Disease
❑ Are you thirsty much of the time ❑ Diabetes (Sugar Disease)
❑ Psychiatric treatment
❑ Fainting or Dizzy Spells
❑ Are you following a diet
❑ X-ray or Cobalt Treatment
❑ Do you have difficulty swallowing
❑ Do you bleed excessively from cuts or wounds
❑ Do you worry a great deal
❑ Do you feel you need psychiatric care or advice
❑ Do you have pain in the chest upon exertion
❑ Ulcers (Stomach or Intestinal)
❑ Venereal Disease (Syphilis or Gonorrhea)
❑ Do you have shortness of breath after mild exercise
❑ Do you have to urinate (pass water) more than 6 times a day
❑ Does your mouth frequently become dry

❑Have you lost or gained weight (more than 10 pounds) in the past year
❑Do you have Cataracts or Glaucoma
❑Has a doctor ever said you have cancer or a tumor
❑Do you have frequent severe headaches
❑Are you under abnormal stress (For example marital, business or social)
❑Do you sometimes take medicine to relieve nervousness
❑Do you have any condition, or problem not listed above? If yes, explain:
❑Do you drink alcohol? How many drinks do you have a day _____ Week _____
❑Do you smoke?

Females
❑Do you have any trouble with your periods? (If you do not menstruate do not check)
❑Did you have any complications during pregnancy
❑Are you pregnant? Due Date: _____
❑Are you taking oral contraceptives (Birth Control Pills)

Dental History
❑Have you had any serious trouble associated with any previous dental treatment? If yes, explain:
❑Do you bleed excessively, after tooth extractions
❑Have you recently had dental x-rays? If yes, when:
❑Have you had undesirable reactions to local or general anesthetics? (for example, Novocaine or Gas)
❑Do you clench or grind your teeth
❑Are your teeth sensitive to cold or sweets
❑Are you dissatisfied with the appearance of your teeth
❑Have you had excessive swelling or pain after oral surgery
❑Have your teeth been cleaned recently
❑Do you have a bad taste in your mouth
❑Does food pack between your teeth
❑Does your jaw click or pop when you chew
❑Have you ever received treatment for periodontal disease
❑Has a dentist ever ground your teeth to correct your bite
❑Are you willing to become actively involved in the treatment of your periodontal disease

Briefly state your feelings toward dentures:
_____
_____

What is your chief complaint concerning your mouth or teeth?

_____

_____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT, IF I HAVE ANY CHANGE IN MY HEALTH, I WILL INFORM DR. AXELRAD AT MY NEXT APPOINTMENT.

_____ _____

Signature Date

I herby consent to all dental and oral surgery procedures performed in this office including x-rays and/or relevant anaethesia as indicated and I accept responsibility for all fees charged for treatment rendered whether covered by insurance or not. In addition, I understand that a fee will be charged for missed appointments by myself where at least 48 hours are not provided. I also give consent to photos being taken and used for treatment planning and patient education. I consent to submission of my dental claims electronically to my insurance company. I also consent to your collection, of any and all personal information about me including personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course of, concerning, or relating to, your dental treatment. I similarly consent to the disclosure to third parties of all such information but only on accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or part of any treatment or service you provide. I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.

_____ _____

Signature Date