

Owen Sound Dental Clinic
WELCOME TO OUR OFFICE
REGISTRATION INFORMATION

Medical Alert	
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Date: _____

Please answer the questions as accurately as you can. If you have any questions or doubts, please ask the treating dentist or our receptionist, who is available to assist you with the completion of this form. All information is **strictly confidential** and will remain with this office. **PLEASE PRINT.**

The patient is an: ADULT CHILD ADULT UNDER GUARDIANSHIP

Name of Guardian: _____

Dr. Mr. Mrs. Ms. Miss Referred by: _____
(last) (first) (initial) (prefers to be called) Birth Date: M ___ D ___ Y ___

Name: _____
(street) (apt#) (city) (postal code) Home Phone: () _____

Address: _____ Bus. Phone: () _____

Age ___ Sex ___ Marital Status ___ May we call you at work? Yes No Employer: _____

Person responsible for account: _____ Name of spouse: _____

Do you have insurance? Yes No Email: _____

Family Physician: _____
(name) (address) Health Card # Phone: () _____

Are you under the care of a Medical Specialist? Yes No Phone: () _____

In case of emergency, please contact: _____ Phone: () _____

1. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain.

_____ YES NO NOT SURE/MAYBE

4. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? _____
 YES NO NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:

_____ YES NO NOT SURE/MAYBE

a) medications _____

b) latex/rubber products _____

c) other, e.g. hayfever, foods _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

_____ YES NO NOT SURE/MAYBE

7. Do you have a disability? Explain below. YES NO

8. Do you have or have you ever had a heart murmur, mitral valve prolapse, or rheumatic fever?

_____ YES NO NOT SURE/MAYBE

9. Do you have a prosthetic or artificial joint? YES NO NOT SURE/MAYBE

11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
 YES NO NOT SURE/MAYBE
12. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
 YES NO NOT SURE/MAYBE
13. Have you ever had hepatitis, jaundice, or liver disease?
 YES NO NOT SURE/MAYBE
14. Do you have a bleeding problem or bleeding disorder?
 YES NO NOT SURE/MAYBE
15. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
 YES NO NOT SURE/MAYBE
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16. Do you have or have you ever had any of the following? Please check.

- | | | | | | |
|---|---|---------------------------------------|--|--|--|
| <input type="checkbox"/> chest pain, angina | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> pacemaker | <input type="checkbox"/> steroid therapy | <input type="checkbox"/> seizures (epilepsy) | <input type="checkbox"/> drug/alcohol dependency |
| <input type="checkbox"/> heart attack | | <input type="checkbox"/> lung disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease | |
| <input type="checkbox"/> stroke | <input type="checkbox"/> prosthetic heart valve | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> thyroid disease | |
| | | <input type="checkbox"/> cancer | <input type="checkbox"/> arthritis | <input type="checkbox"/> diet pill therapy | |

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?
 YES NO NOT SURE/MAYBE

18. Are there any diseases or medical problems that run in your family?
 (e.g. diabetes, cancer, or heart disease) YES NO NOT SURE/MAYBE

19. Do you smoke or chew tobacco products? YES NO NOT SURE/MAYBE

20. Are you nervous during dental treatment? YES NO NOT SURE/MAYBE

21. For women only: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?
 YES NO NOT SURE/MAYBE

(Complete both sides before signing) GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X _____
 PATIENT PARENT GUARDIAN

 (PRINT NAME OF GUARDIAN)