DUNDAS VALLEY
DENTISTRY

MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Date of birth: _____

FULL mailing Address(Home):

Street: _____

City/Postal Code: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Address (Business): _____

_____

_____

Phone: _____

Occupation: _____

In case of emergency, who should we contact?

_____

Relationship: _____

Day-time phone: _____

Name of family doctor:

_____

Phone: _____

Name of medical specialist:

_____

Area of specialty:

_____

Phone:

_____

How did you hear about our office?

_____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Dental Insurance Information

Primary insurance
Insurance Co. Name:
Group/ Policy Number #:
Certificate/ ID Number :
Relation:
Secondary insurance
Insurance Co. Name:
Group/ Policy Number #:
Certificate/ ID Number:
Relation & Birthdate :

MEDICAL HEALTH HISTORY QUESTIONNAIR

Yes / No

1. Are you being treated for any medical condition at the present or have you been O O
treated within the past year? If so, why? _____ O O

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

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

O medications _____

O latex/rubber products _____

O other (e.g. hayfever, foods) _____

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

5. Do you have a prosthetic or artificial joint?

OO6.. Do you have any conditions or therapies that could affect your immune system,
e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? OO

6. Have you ever had hepatitis, jaundice or liver disease? OO

7. Do you have a bleeding problem or bleeding disorder? OO

8. Have you ever been hospitalized for any illnesses or operations? If yes, please OO
explain. _____

9. Do you have or have you ever had any of the following? Please check.

☐ cancer	☐ heart attack	MEDICATION LIST
☐ chest pain, angina	☐ stroke	
☐ steroid therapy	☐ shortness of breath	
☐ diabetes	☐ rheumatic fever	
☐ stomach ulcers	☐ mitral valve prolapse	
☐ arthritis	☐ heart murmur	
☐ seizures (epilepsy)	☐ pacemaker	
☐ kidney disease	☐ lung disease	
☐ thyroid disease	☐ tuberculosis	
☐ drug/alcohol dependency	☐ blood pressure problems	
☐ Asthmas	☐ osteoporosis medications	

10. Are there any conditions or diseases not listed above that you have or have had?
If so, what? _____

11. Are there any diseases or medical problems that run in your family? If so, what? OO
(e.g. diabetes, cancer or heart disease) _____

12. Do you smoke or chew tobacco products? If so, how many cigarettes daily? OO

_____

13. Are you nervous during dental treatment? OO

14. **For women only:** Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?_____ OO

DENTAL HISTORY QUESTIONNAIRE

When was your last dental visit? _____

When was your last dental cleaning visit? _____

When did you last have dental x-rays? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have any dental concerns about your teeth? _____

	YES/NO
Have you been seeing a dentist regularly?	OO
Do any of your teeth ache?	OO
Have you ever been advised to take antibiotics before dental appointments?	OO
Do your gums bleed when you brush?	OO
Do you have any pain when you chew?	OO
Do you feel that you have bad breath?	OO
Have you ever been in a vehicle accident or experienced any blows to your jaw?	OO
Have you ever had any implant surgery in one or both of your jaws or jaw joints?	OO

If you answered "yes," to the last question, who performed the surgery and when was it done?

_____

Are you being followed up by a dental specialist? OO

_____

To the best of my knowledge, the above information is correct/ if I have any changes in my health status of if my medications changed I will inform the dentist and the staff at my next appointment without fail:

Patient/ Guardian signature:

X_____Date:_____

REVIEWED BY DOCTOR (Doctor to sign)

X_____

DUNDAS VALLEY
DENTISTRY

DUNDAS VALLEY DENTISTRY PATIENT PRIVACY ACT

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, home & work telephone numbers, and email addresses. Contact information is collected and used for the following purposes:

To open & update patient files.
To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
To process claims for payment or reimbursement from third-party health benefit providers and insurance company.
To send reminders to patients concerning the need for further dental examinations or, treatments.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients of their health history, family health history, physical conditions, and dental treatments.

Patients' Medical Information is disclosed:

To third party health benefit providers and insurance companies where the patients has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on their behalf.

To other dentists and dental specialist, where we are seeking a second opinion and the patients has consented to us obtaining the second opinion.

To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.
I consent to the collection, use and disclosure of my personal information as set out above.

Date	Print Name	Signature

"See why Dundas is smiling."

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