

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? _____
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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 treated within the past year? If so, why? OO
2. Has there been any change in your general health in the past year? If yes, please explain. OO
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 explain. OO
9. Do you have or have you ever had any of the following? Please check.

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

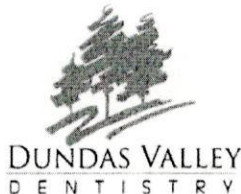
To the best of my knowledge, the above information is correct/ if I have any changes in my health status or if my medications changed I will inform the dentist and the staff at my next appointment without fail:

Patient/ Guardian signature:

X _____ Date: _____

REVIEWED BY DOCTOR (Doctor to sign)

X _____



DUNDAS VALLEY DENTISTRY 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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