HEALTH HISTORY

Please complete the following form as accurately as possible. You will be required to update this form every year. However, if you have any medical changes, please notify us prior to your appointment.

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ Gender M F AHC No. _____ Height _____ Weight _____
DD / MM / YY

Legal Guardian / Custodian / Account Holder (if applicable) _____

Address _____ City _____ Province _____ Postal Code _____

Contact Information

Home No. _____ Work No. _____ Cell. No. _____ Email Address _____

Emergency Contact

Name _____ Telephone No. _____ Relationship _____

Medical Doctor _____ Clinic _____

Allergies? ☐ Yes ☐ No List _____

Medication currently taking and reason (list on reverse, if necessary, or attach medications list):

Drug _____ Reason _____ Drug _____ Reason _____

Drug _____ Reason _____ Drug _____ Reason _____ Pharmacy _____

Do you have or have had any of the following? Please check either 'yes' or 'no' and list the dates of conditions.

YES	NO		YES	NO	
☐	☐	Seizures	☐	☐	Reflux
☐	☐	High / low blood pressure: BP ____ /____	☐	☐	Ulcers
☐	☐	Stroke (Date: _____)	☐	☐	Kidney disease
☐	☐	Heart condition (Type: _____)	☐	☐	Diabetes (Type: _____)
☐	☐	Heart attack (Date: _____)	☐	☐	Thyroid disease
☐	☐	Blood disorders / anemia / clotting problem	☐	☐	History of substance abuse?
☐	☐	Do you smoke? (No. / day_____)	☐	☐	Hepatitis (A, B, C) / jaundice / liver disease
☐	☐	Lung disorder / asthma / COPD	☐	☐	HIV infection / AIDS
☐	☐	History of sleep apnea / history of snoring?	☐	☐	Do you think you might be pregnant? Due: ____)
☐	☐	Cancer / type (Date: _____)	☐	☐	Arthritis (Type: _____)
☐	☐	Depression / Anxiety	☐	☐	Joint replacement (Date: _____)
			☐	☐	Osteoporosis

Important additional information: _____

Have you ever had an operation under general anaesthetic or sedation before? Yes No *(Circle one)* **Date** _____

Is there a family history of: life-threatening anesthetic complications, abnormal reactions to muscle relaxants, malignant hyperthermia or muscle problems (myopathy or muscular dystrophy)? _____

How did you hear about our office?

☐ Internet ☐ Sign ☐ Social Media ☐ Friend/Family _____ ☐ Referring Dentist or Other (specify) _____

Primary Insurance		**Secondary Insurance**	
Insurance Holder		Insurance Holder	
Insurance Holder DOB		Insurance Holder DOB	
Insurance Company		Insurance Company	
Group No.		Group No.	
ID No.		ID No.	

Patient Certification: I hereby certify that this medical and dental history is accurate to the best of my knowledge. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of anesthetic, further medications, anesthetics or IV sedation as indicated. I also consent to the collection, use and disclosure of myself, my child's, or my ward's personal information as set out in the Personal Information Consent form which I have read.

I have full decision-making for the above listed minor or ward of the court.

I understand that I am financially responsible to my dentist for the entire treatment of fees that ay not be covered by my plan or exceed my plan maximum.

Patient (Parent / Guardian) Signature _____ Date _____

Patient (Parent / Guardian) Signature _____ Date _____