ARCHER DENTAL

Advancing dental care in our changing world

Patient Medical History & Information Form

Salutation _____ Last Name_____ First Name _____

Preferred Name _____ Date of Birth (DD/MM/YYYY) _____ Sex _____

Address _____ Unit # _____ City/Province_____

Postal Code _____ Telephone number _____ Alt number _____

May we contact you by email? Yes No Email address _____

How did you hear about us? _____

Emergency Contact _____ Phone number _____

CASL consent - I consent to communicating with this dental office and receiving important information from this office by email, text messaging or social media. This office is committed to never sending spam email and will always take all reasonable precautions to protect my electronic information.

Signature : _____

Insurance Information

Insurance Company _____ Group # _____Cert# _____
Name of Insured _____ DOB _____ Relationship _____

Do You Have Any Additional Insurance? If yes, complete the following:

Insurance Company _____ Group # _____Cert# _____
Name of Insured _____ DOB _____ Relationship _____

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

1. Are you currently being treated for any medical condition or have you been treated within the past year? ○ Yes ◉ No
If yes, please explain? _____
2. When was your last medical checkup? _____
3. Has there been any change in your general health in the past year? ○ Yes ◉ No
If yes, please explain. _____
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ○ Yes ◉ No
If yes, please list them. _____
5. Do you have any allergies or had a bad reaction to any medications? ○ Yes ◉ No
If yes, please list them using the categories below:
a) medications _____
b) latex/rubber products _____
c) other (e.g. hay fever, seasonal/environmental, foods) _____

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7. Do you have or have you ever had asthma? ○ Yes ◉ No
8. Do you have or have you ever had any heart or blood pressure problems? ○ Yes ◉ No
9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ○ Yes ◉ No
10. Do you have a prosthetic or artificial joint? ○ Yes ◉ No
11. Do you smoke or chew tobacco products? ○ Yes ◉ No
11. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ○ Yes ◉ No
12. Have you ever had hepatitis, jaundice or liver disease? ○ Yes ◉ No
13. Do you have a bleeding problem or bleeding disorder? ○ Yes ◉ No
14. Have you ever been hospitalized for any illnesses or operations? ○ Yes ◉ No
If yes please explain _____
15. Are you currently pregnant or breastfeeding? ○ Yes ◉ No

Have you had an **allergic** or **bad reaction** to any of the following (please check) :

aspirin	tetracycline	metals (nickel, gold, silver)
ibuprofen	sulfa	latex
acetaminophen	local anesthetic	other _____
penicillin	codeine	
erythromycin	fluoride	

DO YOU HAVE or HAVE YOU EVER HAD:

chest pain, angina	○ Yes ○ No	arthritis	○ Yes ○ No
heart attack	○ Yes ○ No	steroid therapy	○ Yes ○ No
stroke, TIA	○ Yes ○ No	diabetes (HbA1c =)	○ Yes ○ No
heart murmur	○ Yes ○ No	stomach or duodenal ulcer	○ Yes ○ No
rheumatic or scarlet fever	○ Yes ○ No	digestive disorders (celiac, crohn's etc)	○ Yes ○ No
mitral valve prolapse	○ Yes ○ No	eating disorders (bulimia, anorexia etc)	○ Yes ○ No
tuberculosis	○ Yes ○ No	thyroid disease	○ Yes ○ No
cancer	○ Yes ○ No	drug/alcohol/cannabis use or dependency	○ Yes ○ No
pacemaker	○ Yes ○ No	kidney disease	○ Yes ○ No
Prolonged bleeding (INR > 3.5)	○ Yes ○ No	epilepsy, convulsions (seizures)	○ Yes ○ No
lung disease	○ Yes ○ No	Any lumps or swelling in the mouth	○ Yes ○ No

18. Are there any conditions or diseases not listed above that you have or have had? ○ Yes ○ No
If yes please explain _____
17. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)? □ Yes □ No
If yes please explain _____

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PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

List all medications, supplements, and or vitamins taken within the last two years.

_____ _____

_____ _____

_____ _____

Dental History

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]

Have you ever had trouble getting numb or had any reactions to local anesthetic? ○ Yes ○ No

Do your gums bleed or are they painful when brushing or flossing? ○ Yes ○ No

Have you ever had any teeth become loose on their own (without an injury)? ○ Yes ○ No

Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ○ Yes ○ No

Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? ○ Yes ○ No

Do you frequently get food caught between any teeth? ○ Yes ○ No

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ○ Yes ○ No

Do you clench or grind your teeth together in the daytime or make them sore? ○ Yes ○ No

Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ○ Yes ○ No

Do you wear or have you ever worn a bite appliance? ○ Yes ○ No

Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? ○ Yes ○ No

Have you felt uncomfortable or self-conscious about the appearance of your teeth? ○ Yes ○ No

Photography

I consent to photography, filming, and x-rays of my oral and facial structures and the procedure, and their publication for educational and scientific purposes, provided my identity is not revealed. I give up all rights for compensation for publication of these records.

Patient/Guardian Signature: _____

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

_____ _____

Date Signature

Consent for Collection, Use and Disclosure of Personal Information

I agree that Archer Dental has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy and is in accordance with the Personal Health Information Protection Act, 2004.