Washago Family Dentistry



Patient Code:

Patients last name:_		Firs	t name:		Middle:_	
Telephone #:			ernate phone #:			
			' :		Postal co	de:
Date of birth:		Occ	upation/emplo	yer:		
In case of emergence			-			
Email Address:	-	Do	you have denta	l Insurance? '	Y or N	
			ical History			
Family Physician:		Add	lress/Phone #:_			
Are you currently under med	dical treatment?	If so for what?				
	Do you hav	e allergic or unusual rea	ction to: please cir	cle if yes please	e explain.	
Aspirin	Y or N		Cosmeti	cs	Y or N	
Codeine	Y or N		Metals		Y or N	
Dental Anaesthetic	Y or N		Other m	edicines	Y or N	
Penicillin						
		Have you ever been trea	•	•		
Aids/HIV		Glaucoma				
Anaemia		Hay Fever	·	_	th	· · · · · · · · · · · · · · · · · · ·
Anorexia or Bullmia		Heart Condition			er	
Arthritis		Hemophillia			thritis	
Asthma		Hepatitis			eath	
Bleeding Problems		Liver Disease				
Blood Disorders		High Blood Pressure				
Bowel Problems		Jaundice				
Cancer		Kidney Problems			n	
Coughing up blood		Leukemia				
Diabetes		Lung Disease		Ulcer		Y or N
Drug or Alcohol		Lupus			se	
Emphysema		Mitral Valve Prolapse	Y or N	Other		Y or N
Epilepsy	Y or N	Gastrointestinal disorder	Y or N			
1. Have you ever been hospi	talized or had a s	erious illnesss or had any su	urgery?		Y or N	
2. Are you or have you recei	ved any psychiat	ric care and are you receivir	ng medication for this	?	Y or N	
3. Are you being treated for	any conditions b	y a physician in the last two	years?		Y or N	
4. Have you had any joint re	placements?				Y or N	
5. Do you ever have asthma,	, hayfever, hives	or skin rashes?			Y or N	
6. Do you have any allergies	?				Y or N	
7. Have you had any unexpla	ained weight loss	, increasing thirst, appetite	or urination?		Y or N	
8. Have you ever taken corti	sone?				Y or N	
9. Do you have any problem						
10. Any prolonged bleeding	when cut?				Y or N	
11. Have you ever fainted?_						
12. Are you pregnant or nurs	sing?				Y or N	

Washago Family Dentistry



Anticoagulants (blood thinners) Drugs for heart trouble Nitroglycerin V Antidepressants High blood pressure Sedatives or sleeping pills C 14. Have you ever or are you now receiving radiation therapy or chemotherapy? Y or N 15. Do you have any in-dwelling catheters? Y or N 16. Do you smoke? If so how much? V or N 17. Is there anything about your medical history that has not been mentioned? Y or N 18. Have we missed anything? Dental History 1. When was your last dental Visit? 2. How often do you have a dental check up? 3. Have you ever had an unfavourable dental experience? 4. Do you have any discomfort in your teeth due to hot or cold, sweets, biting or chewing? Y or N 5. Does food catch between your teeth? 6. Do your gums bleed when brushing or flossing? Y or N 7. Are you conscious of bad breath or bad taste in your mouth? 8. Do you favour one side when chewing? Y or N	Drugs for heart trouble Nitroglycerin Water pills High blood pressure Sedatives or sleeping pills Other	13. Have you taken any drugs, pills, me	dicines or tablets in the past two years	? (please circle)	Y or N
Antidepressants High blood pressure Sedatives or sleeping pills 14. Have you ever or are you now receiving radiation therapy or chemotherapy? 15. Do you have any in-dwelling catheters? 16. Do you smoke? If so how much? 17. Is there anything about your medical history that has not been mentioned? 18. Have we missed anything? Dental History 1. When was your last dental Visit? 2. How often do you have a dental check up? 3. Have you ever had an unfavourable dental experience? 4. Do you have any discomfort in your teeth due to hot or cold, sweets, biting or chewing? 5. Does food catch between your teeth? 6. Do your gums bleed when brushing or flossing? 7. Are you conscious of bad breath or bad taste in your mouth? 8. Do you favour one side when chewing? 9. Are you happy with your smile? 10. If you could, would you change anything about your smile? 11. Do you ever wake up with a headache or have a tired feeling in your face or jaw? 12. Does your jaw pop, click or grate when opening widely? 13. Do you clench or grind your teeth? 14. Have you lost any teeth due to abcess, accident, decay or gum disease? (please circle) 15. Yor N 16. Do you floss or sleeping pills 16. Yor N 17. Or N 18. Have you lost any teeth due to abcess, accident, decay or gum disease? (please circle)	High blood pressure Sedatives or sleeping pills Other	Antibiotics or sulfa drugs	Cortisone	Insulin or Diabetes drugs	Tranquilizers
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15. Was tooth replacement suggested?Y or N	e undersigned consent to the performing of dental and oral surgery procedures agreed ble including the use of local anaesthetic and/or relative analgesia as indicated, and	14. Have you lost any teeth due to abce	Y or N		
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