Welcome to Heritage Periodontics

PATIENT INFORMATION:

Date: M D Y

□ Mr. □Mrs. □Ms. □Miss □Dr. First Name_____ M.I.____ Last Name_____
Sex: □Male □Female Birth Date _____ Age _____ e-mail _____
Address _____ City _____ Province_____
Postal Code _____Home Tel. (____) _____ Cell (_____) _____
Occupation _____ Employer _____
Business address _____
City_____ Province _____ Postal Code _____ Tel. (_____) _____
Emergency Contact _____ Tel. (____) _____ Relationship _____
Have you ever been a patient of our practice? □Yes □No Referred by _____
Dentist _____ Phone _____

INSURANCE INFORMATION:

Marital Status: □Married □Divorced □Widow □Single □Legally Separated
Student: □Full Time □Part Time □Not School _____

PRIMARY INSURANCE:

Employer _____Insurance Co. _____
Group Policy/Plan No._____ Certificate/ID No._____

SECONDARY INSURANCE: (if applicable)

Policy Holder: First Name _____ M.I. ____ Last Name_____
Birth Date _____ Sex: □Male □Female Employer _____
Insurance Co. _____
Group Policy/Plan No._____Certificate/ID No. _____

MEDICAL HISTORY:

		Y	N
1.	Are you in good health?_____	□	□
2.	Are you under the care of a physician? If yes, please explain:_____	□	□
	_____		
3.	Physician:_____ Phone:_____		
4.	When was your last medical check up?_____		
5.	Have you been hospitalized in the past 2 years? _____	□	□
6.	Have you ever had any complications following a medical or dental procedure?_____	□	□
7.	Has your physician ever told you to have antibiotics prior to dental procedures?_____	□	□
8.	Is there a family history of diabetes, cancer or heart disease? _____	□	□
9.	Has your weight, appetite or energy level changed dramatically recently?_____	□	□
10.	Do you follow a special diet, or are you on a diet pill therapy? _____	□	□
11.	Have you ever had any injury or surgery to your face or jaw?_____	□	□
12.	Do you bleed excessively from a cut or injury, or bruise easily? _____	□	□
13.	Do you wear glasses or contact lenses? _____	□	□
14.	Do you smoke or chew tobacco products?_____	□	□

Please indicate if you have, or have you had any of the following disease, medical conditions, or procedures:

Y	N		Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Glaucoma/eye disease	☐	☐	Organ transplant/medical implant
☐	☐	Alcohol abuse	☐	☐	Head/neck injuries	☐	☐	Osteoporosis/Osteopenia
☐	☐	Anemia	☐	☐	Heart disease or attack	☐	☐	Osteonecrosis
☐	☐	Angina/chest pains	☐	☐	Heart murmur	☐	☐	Psychiatric treatment
☐	☐	Arthritis/rheumatism	☐	☐	Heart pacemaker	☐	☐	Radiation treatment or chemotherapy
☐	☐	Artificial heart valve	☐	☐	Heart surgery	☐	☐	Scarlet fever -- rheumatic fever
☐	☐	Artificial joints (hip, knee)	☐	☐	Hepatitis A, B, C	☐	☐	Sinus trouble
☐	☐	Asthma	☐	☐	High/low blood pressure	☐	☐	Stomach or intestinal problems/ulcers
☐	☐	Blood disorder	☐	☐	Hodgkins disease	☐	☐	Stroke
☐	☐	Bronchitis	☐	☐	Immune system problems	☐	☐	Swollen ankles
☐	☐	Cancer	☐	☐	Inflammatory bowel disease	☐	☐	Thyroid disease
☐	☐	Congenital heart lesions	☐	☐	Jaundice	☐	☐	Tuberculosis
☐	☐	Crohn's disease	☐	☐	Kidney disease	☐	☐	Venereal disease
☐	☐	Diabetes	☐	☐	Liver disease			
☐	☐	Dialysis	☐	☐	Lung disease			
☐	☐	Difficulty climbing 1-2 flights of stairs	☐	☐	Lupus			
			☐	☐	Malignant Hyperthermia			
☐	☐	Epilepsy or seizures	☐	☐	Mental/nervous disorder			
☐	☐	Fainting or dizzy spells	☐	☐	Mitral valve prolapse			

For women only:
Is there a possibility of pregnancy? ☐Yes ☐No If yes, expected date of delivery _____
Are you nursing? ☐Yes ☐No

MEDICATION & ALLERGIES:

	Y	N
1. Have you ever reacted adversely to any medications or injections? Eg. Penicillin, other antibiotics, aspirin, codeine, local anaesthetic (freezing), nitrous oxide or any other medication? If yes, please explain_____	☐	☐
2. Are you taking any medication(s) – prescribed, natural, herbal or homeopathic? Please list. _____ _____	☐	☐
3. Do you have any allergies to drugs, latex or other? If yes, please list _____ _____	☐	☐

I certify that I have read and understand the questions above. I acknowledge that my questions, if any about the inquires set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I authorize the release of all pertinent information relative to my dental and medical history to any dentist or physician involved in my treatment and to my dental insurance company, here applicable.

Date:_____Patient signature:_____