WELCOME TO LIMESTONE CITY DENTAL CENTRE

In order to render optimum health service it is necessary to became acquainted with your vital information. Of course all information is strictly confidential. Although some questions may seem uninportant at the moment. They may be vital in case of emergency. Therefore please answer every question. Thank you.

PERSONAL INFORMATION

Today's Date _____

Name _____ Date of Birth _____ Age _____

Address _____ Gender M ☐ F ☐ Other _____

City _____ Postal Code _____ Email _____

Phone Home _____

☐ By checking this box. I agree to receive digital communications from Limestone City Dental. I understand that I may unsubscribe at any time by clicking the Unsubscribe" link at the bottom of any email.

Work _____

Cell _____ Occupation _____

In case of emergency please contact: (Name) _____ (Tel) _____

Name of person responsible for this account (if under 18 years old) _____

Name of Employer _____ Are you insured? Yes ☐ No ☐

Insurance Company Name _____

Policy No. _____ ID No. _____

When was your last dental examination? _____

Who referred you to our office? _____

MEDICAL HISTORY

Physician's Name _____ Telephone _____

Date of last medical exam _____ Blood Pressure _____

1 Have you ever been hospitalized or had a serious illness? Yes ☐ No ☐

If so, what/when? _____

2 Are you being treated for any condition by a physician? Yes ☐ No ☐

If so, what? _____

3 Are you presently taking any medication? Yes ☐ No ☐

List medication _____

_____

_____

4 Do you regularly take dietary supplements or herbal medicines? Yes ☐ No ☐

Please specify: _____

5 Have you ever had or been treated for:

- ☐ heart trouble
- ☐ heart attack
- ☐ high blood pressure
- ☐ tuberculosis
- ☐ persistent cough
- ☐ coughing up blood
- ☐ shortness of breath
- ☐ arthritis
- ☐ bone or muscle problems
- ☐ ulcer
- ☐ gastrointestinal problems
- ☐ kidney problems
- ☐ diabetes
- ☐ liver problems
- ☐ thyroid problems
- ☐ bleeding problems
- ☐ anaemia
- ☐ glaucoma
- ☐ epilepsy
- ☐ venereal disease
- ☐ skin disorder

PLEASE TURN OVER

CONTINUED...

☐ pain in chest ☐ hepatitis ☐ HIV (AIDS)
☐ osteoporosis ☐ jaundice ☐ Heart Surgery

Other _____ Yes ☐ No ☐

6 Do you ever have asthma, hayfever, hives, skin rash? Yes ☐ No ☐

7 Have you ever had an adverse reaction to any drug including local anaesthetic? Yes ☐ No ☐

If so, what? _____

8 Are you allergic to any drugs or medication? Yes ☐ No ☐

Penicillin ☐ Erythromycin ☐ Sulpha ☐ Aspirin ☐ Codeine ☐ Tetracycline ☐

Barbituates ☐ Latex rubber ☐ Other

9 Do you have any problems when cut or bruised? Yes ☐ No ☐

10 Have you had or are you having radiation therapy or chemotherapy? Yes ☐ No ☐

11 Have you ever fainted? Yes ☐ No ☐

12 Are you pregnant or nursing? Yes ☐ No ☐

13 Do you smoke? If yes, how long? Yes ☐ No ☐

14 Have you ever had an adverse reaction to any metals, jewelery, etc.? Yes ☐ No ☐

15 Have you ever had a joint replacement? Yes ☐ No ☐

16 Do you require antibiotics prior to dental treatment? Yes ☐ No ☐

17 Do you or have you ever had: Artificial Heart Valve, .Endocarditis.or.P.eri.carditis? Yes ☐ No ☐

18 Have you taken any medicinal or recreational drugs that could alter your awareness /ability to provide informed consent today'? Yes ☐ No ☐

19 Is there anything that the dentist should know about your medical history that has not been mentioned? (explain) _____ Yes ☐ No ☐

MEDICAL UPDATE

1. Date _____ Initials _____
   Changes _____

2. Date _____ Initials _____
   Changes _____

3. Date _____ Initials _____
   Changes _____

4. Date _____ Initials _____
   Changes _____

5. Date _____ Initials _____
   Changes _____

6. Date _____ Initials _____
   Changes _____

The medical history has been reviewed by the dentist and the dental hygienist may proceed with scaling.

Dentist's Signature _____

By attending this dental office I provide consent to treatment for my oral health needs as determined by the dentist and myself.

Patient's Signature _____ Date _____