MEDICAL HISTORY QUESTIONNAIRE

NAME: MR. /MISS /MRS. / MS. / DR.

WATERFRONT DENTISTRY by Paul's

EMAIL:

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAYTIME PHONE:

NAME OF FAMILY DOCTOR

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

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 being treated for any medical condition at the present or have you been treated within the past year? If so why?

☐ Yes ☐ No ☐ Not sure / Maybe

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.

☐ Yes ☐ No ☐ Not sure / Maybe

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

☐ Yes ☐ No ☐ Not sure / Maybe

5. Do you have allergies? If you answered yes, please list using the categories below:

☐ Yes ☐ No ☐ Not sure / Maybe

a) medications
b) latex/rubber products
c) other e.g. hayfever, foods

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

☐ Yes ☐ No ☐ Not sure / Maybe

7. Do you have or have you ever had asthma?

☐ Yes ☐ No ☐ Not sure / Maybe

8. Do you have or have ever had any heart or blood pressure problems?

☐ Yes ☐ No ☐ Not sure / Maybe

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

☐ Yes ☐ No ☐ Not sure / Maybe

10. Do you have a prosthetic or artifical joint? ☐ Yes ☐ No ☐ Not sure / Maybe

11. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No ☐ Not sure / Maybe

12. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ Yes ☐ No ☐ Not sure / Maybe

13. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not sure / Maybe

14. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not sure / Maybe

15. Have you ever been hospitalized for any illness or operations? If yes, please explain. ☐ Yes ☐ No ☐ Not sure / Maybe

16. Do you have or have your ever had any of the following? Please check.

☐ Chest pain, angina	☐ Shortness of breath	☐ Pacemaker	☐ Steriod therapy	☐ Seizures (epilepsy)
☐ Heart attack	☐ Prosthetic heart valve	☐ Lung disease	☐ Diabetes	☐ Kidney disease
☐ Stroke	☐ Cancer	☐ Tuberculosis	☐ Stomach ulcers	☐ Thyroid disease
☐ Arthritis	☐ Diet pill therapy	☐ Drug/alcohol dependancy		

17. Are there any conditions or diseases not listed above that you have or have had? If so, what?

18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ Yes ☐ No ☐ Not sure / Maybe

19. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not sure / Maybe

20. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not sure / Maybe

21. **For women only:** Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? ☐ Yes ☐ No ☐ Not sure / Maybe

As we schedule a dedicated time to meet your dental needs, we ask for a 48 hour notice of cancellation, which will allow us to use that time slot to accommodate another patient. ***FAILURE TO PROVIDE US WITH PROPER NOTICE WILL RESULT IN A FEE OF $50.***

Another new protocol is to ESCORT YOU RIGHT INTO AND OUT OF THE OFFICE once your procedure is done. This is the reason we will need a credit card (or any payment method) on file to cover any balance owing after the insurance has paid their share. We will do our very best with your insurance company, but because of our new protocols in place, we advise that you contact your insurance company and get the proper breakdown of your benefits so that there will be no surprises.

1. Do you pay according to the current fee guide?

2. How much is your deductable?

3. Please provide the percentage coverage for: Basic Dental Work? Major Dental Work?

4. Please provide the maximum amount you can spend per year for BASIC and MAJOR dental work.

5. Please define whether your BASIC and MAJOR coverage is a COMBINED MAXIMUM.

6. How often can the following be done: RECALL Exam? COMPLETE Exam? PANORAMIC X-RAY?

7. How many scaling/teeth cleaning units do you have per year?

8. What is your benefit year cycle date?

To the best of my knowledge, the information above is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

DENTIST NOTES: