

# Dentistry in the Village

Date: \_\_\_ / \_\_\_ / \_\_\_  
M D Y

## PATIENT INFORMATION

<b>PATIENT IS AN:</b>	ADULT <input type="checkbox"/>	CHILD <input type="checkbox"/>	NAME OF PARENT/GUARDIAN: _____
Name: _____		Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Mr. <input type="checkbox"/>	
	<small>(last)</small>	<small>(first)</small>	<small>(middle)</small>
Home: _____			
	<small>(street)</small>	<small>(city)</small>	<small>(province) (postal code)</small>
Home Phone: (____) _____		Cell Phone: (____) _____	
Business Phone: (____) _____			
E-mail: _____@_____			
Date of Birth: ___ / ___ / ___		Age: _____ Sex: _____ Marital Status: _____	
	<small>M</small>	<small>D</small>	<small>Y</small>

<b>OCCUPATION:</b>	_____		
Employed By:	_____	Phone: (____) _____	Ext: _____
Spouse Employed By:	_____	Phone: (____) _____	Ext: _____

<b>MEDICAL OFFICE:</b>	_____		
Family Physician:	_____	Phone: (____) _____	_____
Medical Specialist:	_____	Phone: (____) _____	_____

<b>PERSON RESPONSIBLE FOR ACCOUNT:</b>	SELF <input type="checkbox"/>	OTHER <input type="checkbox"/>	<b>➔</b>	Name: _____
Address: _____				E-mail: _____
Home Phone: (____) _____		Business Phone: (____) _____		Cell Phone: (____) _____

<b>IN CASE OF EMERGENCY:</b>	Please Notify: _____	Relationship: _____
Home Phone: (____) _____		Business Phone: (____) _____
Cell Phone: (____) _____		
Is any other member of your family or relative a patient at our office?		

<b>REASON FOR TODAY'S VISIT:</b>	Examination <input type="checkbox"/> Emergency <input type="checkbox"/> OTHER <input type="checkbox"/> _____
Who may we thank for referring you to our office?	

MEDICAL HISTORY:	Please check YES or NO. <i>If NOT SURE, Check NS.</i>			NO	NS	YES	
Are you presently under Doctor's care? Why?							
Have you been under Doctors care in the past two years? Why?							
Have you taken any medications, pills or drugs in the past two years?							
Are you presently taking any medications, pills or drugs?							<i>If Yes, list them here:</i>
Are you presently taking any Natural Supplements? (Vitamins or Herbal Remedies)							
Have you ever had Tonsillitis?							
Have you ever been hospitalized in the pas two yeas? (If yes why?)							
Have you had any type of surgery? When & Why?							
When was your last complete physical examination?							
Have you ever had pain is your chest or shortness of breath?							
Have you ever been diagnosed as having a tumor or cancer? When & Where.							
Have you ever taken cortisone/steroid medication?							
Do you experience problems with healing?							
Do you bruise easily or bleed excessively?							

## MEDICAL HISTORY

<b>MEDICAL ALERT</b>	<u>CONDITION</u>	<u>PREMEDICATION</u>	<u>ALLERGIES</u>
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ALLERGIES	Please check any medications you are allergic to or have reacted adversely to:				
<input type="checkbox"/> Penicillin	<input type="checkbox"/> Sulpha drugs	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Naproxen	<input type="checkbox"/> Percocet	<input type="checkbox"/> Nitrous Oxide
<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Chlorhexidene (Peridex)	<input type="checkbox"/> Tylenol #2, #3, #4	<input type="checkbox"/> Toradol	<input type="checkbox"/> Darvon	<input type="checkbox"/> Latex
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Aspirin	<input type="checkbox"/> 222, 282, 292	<input type="checkbox"/> Demerol	<input type="checkbox"/> Valium	<input type="checkbox"/> Metal
<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Ibuprofen (Advil)	<input type="checkbox"/> Codeine	<input type="checkbox"/> Percodan	<input type="checkbox"/> Ativan	
<input type="checkbox"/> Food allergies, please list: _____					
<input type="checkbox"/> Other: _____					

MEDICAL CONDITIONS	Please check all the following conditions you presently have, or have had. <i>If NOT SURE, Check NS.</i>										
	NO	NS	YES		NO	NS	YES		No	NS	YES
Chest Pain/Angina				Kidney Disease				Gout			
Heart Attack				Liver Disease				Psychiatric Care			
Stroke				Jaundice				Nervous Problems			
High Blood Pressure/ Hypertension				Thyroid Disease				Anemia			
Low blood Pressure				Lung Disease				Blood Disorders			
Heart Failure				Tuberculosis				Sickle Cell Anemia			
Rheumatic Fever				Asthma				Epilepsy or Seizures			
Mitral Valve Prolapse				Emphysema				Hemophilia			
Artificial Heart Valve				Sinus Problems				Venereal Disease			
Heart Surgery				Digestive Disorders (Acid Reflux)				Herpes			
Heart Murmur				Stomach Ulcers				Hepatitis A, B, C			
Fainting Spells				Bowel Disorder				AIDS/HIV			
Pacemaker				Artificial Joints				Cancer			
Stroke				Multiple Sclerosis				Radiation Treatment			
High Cholesterol				Muscular Dystrophy				Chemotherapy			
Diabetes				Head/neck Injuries				Auto Immune Disease			
Glaucoma				Arthritis				Alcoholism/ Drug Addiction			
Is there anything we have not mentioned that you think we should know regarding your medical history? _____											

<b>WOMEN ONLY:</b>	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking Birth Control Pills? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you taking Fertility drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Office Policy (please read)**

1. Please help us to maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore at least 48 hours NOTICE must be given if cancellation is absolutely necessary. A fee may apply.
2. Office policy is that services are paid for each visit as they are performed. However, in certain circumstances arrangements for payment may be made by the consulting doctor.
3. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE PATIENT AND THE PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THEIR ACCOUNTS. We will prepare any necessary forms or reports to help collect your benefits from insurance companies.

**Patient's Signature:** \_\_\_\_\_