Avonlea Dental Clinic
5287 Rutherford Rd
Nanaimo BC V9T5N9

(250)756-1441
avonleadental@telus.net

Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Which pharmacy do you use?

Have you ever had complications following dental treatment?

Are you currently under the care of a physician due to a specific condition?

Have you been hospitalized for surgery or illness?

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Do you use tobacco (smoking or chewing).

◯ Yes ◯ No

If so how many years have you been using tobacco and how frequently?

Please check any conditions that may apply:

☐ *Pre-Med/Antibio	☐ *Pre-Med-NOT NEEDED	☐ *See Chart	☐ Allergies
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Aspirin Allergy
☐ Asthma	☐ Barbiturates Allergy	☐ Bisphosphonates used	☐ Blood Disease
☐ Cancer	☐ Chemotherapy	☐ Codeine Allergy	☐ Contraceptive Use
☐ Corrective lenses	☐ Diabetes	☐ Dizziness	☐ Epilepsy
☐ Excessive Bleeding	☐ Excessive Bruising	☐ Fainting	☐ Gastro-Intestinal
☐ Glaucoma	☐ Growths	☐ Hard To Freeze	☐ Hay Fever
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV+ (AIDS)	☐ Hives	☐ Iodine Allergy
☐ Jaundice	☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease
☐ Local Anesth Allergy	☐ Low Blood Pressure	☐ Mental Disorders	☐ Multiple Sclerosis
☐ Muscular Dystrophy	☐ Nervous Disorders	☐ Pacemaker	☐ Penicillin Allergy
☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Sinus Problems	☐ Skin Rash	☐ Stomach Problems
☐ Stroke	☐ Sulfa Allergy	☐ Thyroid Disease	☐ TMJ
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Venereal Disease

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Notes on medical conditions:

Do you have any other conditions, diseases, or allergies not listed that we should be aware of?

Please list all prescription or non-prescription medications taken:

1.

2.

3.

4.

5.

6.

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7.

8.

9.

10.

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

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What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

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If you could change anything about your mouth, teeth, or smile, what would it be?

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date:

Relationship to Patient:

Response Date: