We appreciate referrals. Whom may we thank for referring you? _____

Date: _____
Day/Month/Year

CONFIDENTIAL PATIENT INFORMATION

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.

Name: _____ _____ _____ _____
Title First Middle Last

Address: _____ _____ _____ _____ _____
Apt Street City Prov. Postal Code

Home phone: _____ Cell: _____

Business: _____ Email: _____

Occupation: _____ Place of Work: _____

Date of Birth (Day/Month/Year): _____

Dental Insurance: YES NO

Name of Company: _____

Person responsible for account: Same as above or _____

In case of emergency please notify: Name: _____

Relationship: _____ Phone: _____

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

1. Are you being treated for any medical condition at the present or have you been treated within the past year?
   YES NO NOT SURE If yes, why? _____

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year?
   YES NO NOT SURE If yes, please explain. _____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
   YES NO NOT SURE
   If Yes, Please specify:
   Drug : _____ Reason: _____
   Drug: _____ Reason: _____
   Drug: _____ Reason: _____
   Drug: _____ Reason: _____

5. Do you have any allergies? :
   YES NO NOT SURE
   If Yes Please Specify: 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?
   YES NO NOT SURE If yes, please explain. _____

7. Do you have or have you ever had asthma?
   YES NO NOT SURE

8. Do you have or have you ever had any heart or blood pressure problems?
   YES NO NOT SURE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
   YES NO NOT SURE

10. Do you have a prosthetic or artificial joint?
    YES NO NOT SURE

11. 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

12. Have you ever had hepatitis, jaundice or liver disease?
YES NO NOT SURE

13. Do you have a bleeding problem or bleeding disorder?
YES NO NOT SURE

14. Have you ever been hospitalized for any illnesses or operations?
YES NO NOT SURE If yes, please explain.

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

chest pain, angina	heart attack	stroke	shortness of breath
rheumatic fever	mitral valve prolapse	heart murmur	pacemaker
lung disease	tuberculosis	diabetes	arthritis
cancer	steroid therapy	stomach ulcers	seizures (epilepsy)
kidney disease	thyroid disease	drug/alcohol dependency	osteoporosis medications (e.g. Fosamax - Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
YES NO NOT SURE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
YES NO NOT SURE

18. Do you smoke or chew tobacco products?
YES NO NOT SURE

19. Are you nervous during dental treatment?
YES NO NOT SURE

20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
YES NO NOT SURE

21. Do you have any illness not included above? Please specify:
YES NO NOT SURE

DENTAL HISTORY

1.Are you having any discomfort at this time? YES NO
If yes, please explain. _____
2.Have you been under regular care by a dentist? YES NO
3.Name of previous dentist:_____ Last dental visit_____
4.What was done at that time? _____
5.Do your gums feel tender or swollen? YES NO
6.Do you catch food between your teeth? YES NO
7.Do you wish to keep your natural teeth? YES NO
8.Have you ever had a problem with local and general anaesthetic? YES NO
9.Are you tense during dental visits? YES NO
10. Would you be interested in improving the appearance of your teeth? YES NO
11. Describe what you would like done with your teeth: _____
_____ _____

12. Do you currently experience? (Please check)

loose teeth	sensitive teeth	headache	spaced or crooked teeth
unsatisfactory dentures	bad breath	neck pain	gagging
bleeding gums	sore gums	popping/clicking jaw	earache
unexplained nose bleeds	missing teeth		

GENERAL RELEASE

I, _____the undersigned, state that I have provided an accurate and complete medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding this medical-dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as maybe necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services to me or my dependents.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE :_____

RESET PRINT SAVE

To email the from please save your form and send it manually to info@Longfieldsdental.com using your email service.