BANCROFT DENTAL CENTRE

Dr. Moledina & Associates

68 Hastings St N Bancroft ON K0L1C0

MEDICAL & DENTAL QUESTIONAIRE

Name: _____ **Perferred Name:** _____

Date of Birth: _____/_____/_____

Name of Parent (If under 18): _____ Tel: _____

Home Address: _____ City: _____ Prov: _____ Postal Code: _____

Tel# Home: _____ Cell: _____ Email _____

EMERGENCY CONTACT

Name: _____ Relationship _____ Phone _____

Family Doctor: _____ City _____ Phone _____

Specialist: _____ City _____ Phone _____

Pharmacy: _____ City _____

INSURANCE

Do You Have Dental Insurance? _____ YES _____ NO (If yes, please present Ins Card to reception)

Name of Insurance Holder: _____ Date of Birth: _____/_____/_____

Insurance Co _____ Policy/Plan # _____ Cert/ID # _____

MEDICAL HISTORY - The following information is required to enable us to provide you with the best possible dental care. All information is held in strict confidence. Our dental professionals will review your medical history with you. Please feel free to ask questions if you need clarification. *We ask that you complete this form to the best of your abilities and knowledge.*

Are you being treated for any medical conditions presently or has your medical changed in the past year? _____ YES _____ NO _____

If yes, please explain: _____

Are you taking any medications, non-prescription drugs or natural supplements of any kind? _____ YES _____ NO _____ NOT SURE

Please provide your list to reception or list here: _____

_____

Do you have any allergies (environmental, medications, food etc.) _____ YES _____ NO _____ NOT SURE

Please list: _____

Have you had any peculiar or adverse reactions to any medications or injections? _____ YES _____ NO _____ NOT SURE

Do you have or ever have had any Heart or Blood Pressure problems? _____ YES _____ NO _____ NOT SURE

Do you have or ever have had a replacement or repair of a Heart Valve, Infection of the Heart (Endocarditis), Heart condition from birth (Congenital Heart Disease), Heart Transplant, or Pacemaker? _____ YES _____ NO _____ NOT SURE

Please list/explain: _____

Have you ever had to take a pre-medication (Antibiotic Prophylaxis) prior to dental treatment? _____ YES _____ NO _____ NOT SURE

Do you have a prosthetic or artifical knee/joint/hip replacement? _____ YES _____ NO When? _____

Have you ever been hosptialized for any illness or had any surgery? _____ YES _____ NO When? _____

Please explain: _____

PLEASE COMPLETE THIS SECTION - Please circle if you have had any of the following:

Epilepsy or Seizures	Heart attack/failure	Kidney Disease
Thyroid disease	Heart murmur	Malignant Hypothermia
Stroke	Blood disorder/bleeding disorder	Drug/Alcohol Dependency
Glaucoma	Chest Pain/Angina	Osteoporosis
Alzheimer's Disease / Dementia	Mitral Valve Prolapse	Hepatitis/Jaundice
Frequent headaches	Stomach Ulcers	Diabetes (Type 1 or 2)
Depression, anxiety, bipolar	Shortness of Breath/Asthma	Arthritis
Mental Health Care	Lung Disease/COPD	Organ Transplant
Rheumatic Fever	Tuberculosis	Cancer
HIV/AIDS	Steroid Therapy	Leukemia

Are there any other conditions/diseases not listed above that you have or had? _____

Are there any family history of diseases? _____

Please circle if you: Smoke Use Tobacco Vape Use Marjuana How often? _____

As Applicable: Are you pregnant? _____ YES _____ NO _____ NOT SURE If yes, expected delivery date: _____
Are you breastfeeding? _____ YES _____ NO Are you taking Birth Control? _____ YES _____ NO

DENTAL HISTORY

When was you last dental visit? _____ Last cleaning? _____

Who was your previous Dentist? _____ City: _____

Have you had any x-rays taken in the past year? _____ YES _____ NO _____ NOT SURE

What are your dental concerns at present? Please circle: Bleeding Gums Crooked Teeth Cosmetic/Whiter Teeth
Bad Breath Loose Teeth Food Trapping Sensitive Teeth Toothache/Cavities Loose Denture/Repair

Have you had any teeth removed due to accident, cavities or gum disease? _____ YES _____ NO _____ NOT SURE

Any complications after extractions? _____ YES _____ NO _____ NOT SURE

Are you anxious about dental visits _____ YES _____ NO _____ NOT SURE

Are you interested in Nitrous Oxide Sedation? (Laughing Gas) _____ YES _____ NO _____ NOT SURE

Patient Certification and Consent: I, the undersigned, certify that all the above medical and dental information to be true to the best of my knowledge and that I have not omitted any pertinent information. I assume all responsisbility for fee associated with procedures. I agree to the office privacy policy and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and determination of benefits. I authorize the dentist and other dental professionals within the office to treat me and I assume full responsibility for the fess. I am aware that I *may* be charged a fee for any no show or short notice cancellation of appointments. I consent to the sharing of my medical/dental health and history with my family/specialist Doctor and/or any Dental Professional that I may be referred to, as it pertains to my ongoing or future dental care/treatments.

_____ _____

Signature (Parent/Guardian if patient under 18 years of age) Date