WELCOME TO OUR DENTAL OFFICE

(OFFICE USE ONLY)
MEDICAL ALERT Y_____ N_____

PLEASE PRINT

The information that is requested in the questionnaire, dental history and medical history is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly (See policy posted in office).

1. PERSONAL INFORMATION

NAME ____________________________________ ____________________________________
(LAST NAME) (FIRST NAME)

ADDRESS ________ ____ ________________
(NUMBER) (STREET) (APT #)

______________________ ______________________ __________________________
(CITY) (PROVINCE) (POSTAL CODE)

PHONE NUMBER ______________________ ______________________ __________________________
(HOME) (WORK) (CELL)

DATE OF BIRTH ______/______/________ **PLEASE CIRCLE ONE** MALE FEMALE
M D Y

EMAIL ADDRESS: ____

PLEASE CIRCLE THE BEST WAY TO CONFIRM YOUR APPOINTMENTS: HOME CELL WORK EMAIL

IN CASE OF EMERGENCY, PLEASE CONTACT: ____________________________ _________________________
(NAME) (PHONE NUMBER)

NEAREST RELATIVE NOT LIVING WITH YOU: ____________________________ _________________________
(NAME) (PHONE NUMBER)

2) FINANCIAL INFORMATION

-This information is necessary to process invoices and apply payments

Person responsible for account: Self ______ Other ______________________ ______________________
(NAME) (PHONE NUMBER)

DENTAL INSURANCE YES ________ NO________ (IF YES PLEASE PROVIDE INFORMATION BELOW)

PRIMARY DENTAL INSURANCE

SUBSCRIBER'S NAME ______________________________

SUBSCRIBER'S DATE OF BIRTH _____/_____/________
M D Y

EMPLOYER ___________________________________

INSURANCE COMPANY ___________________________

GROUP/POLICY # _______________________________

CERT/ID # _____________________________________

SECONDARY DENTAL INSURANCE

SUBSCRIBER'S NAME ______________________________

SUBSCRIBER'S DATE OF BIRTH _____/_____/_________
M D Y

EMPLOYER ___________________________________

INSURANCE COMPANY ___________________________

GROUP/POLICY # _______________________________

CERT/ID # _____________________________________

I hereby assign my benefits, payable from claims submitted electronically, to Fenworth Dental.
I authorize payment directly to the office and release of any information pertaining to the claim(s).
This authorization shall continue in effect until the undersigned revokes the same.

________________________________ ________________________

Signature of subscriber **Date**

PATIENT NAME: ___________________________________ **DATE OF BIRTH (D,M,Y):**_____________________

HEALTH HISTORY

THE FOLLOWING INFORMATION IS REQUIRED BY THE DENTIST TO ASSIST IN PROPER DIAGNOSIS AND TREATMENT.
ALL INFORMATION IS CONFIDENTIAL.

MEDICAL DOCTOR'S NAME: ____ PHONE NUMBER: ________________________________

PLEASE CIRCLE YES OR NO TO EACH QUESTION BELOW. IF UNSURE OF A QUESTION, PLEASE CONSULT WITH THE DENTIST.

1. Are you being treated for any medical condition at present or within the last two years? .... YES NO
If yes, please specify. ____
2. Have you been a patient in the hospital during the last two years? .... YES NO
If yes, please specify. ____
3. Are you taking or have recently taken any prescription or non-prescription drugs? .... YES NO
If yes, please specify. ____
4. Are you allergic or have you reacted adversely to any of the following medications? .... YES NO
Penicillin, or other antibiotics, aspirin, codeine, local anesthetic (freezing), nitrous oxide
5. Do you have any of the following? (If yes, please circle which one applies) .... YES NO
Asthma, hay fever, food allergies, metal or latex allergies, skin rashes or hives?
6. Are you aware of being allergic to any other medications or substances? .... YES NO
If yes, please specify. ____
7. Do you bleed excessively from a cut or injury, or bruise easily? .... YES NO
8. Do your ankles, feet or hands swell? .... YES NO
9. Has your weight, appetite or energy level changed dramatically recently? .... YES NO
10. Do you follow a special diet, or are you on a diet pill? .... YES NO
11. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? .... YES NO
12. Have you been tested HIV positive? .... YES NO
13. Have you ever had any injury or surgery to your face or jaws? .... YES NO
14. Do you wear eye glasses or contact lenses? .... YES NO
15. Do you smoke or use any other forms of tobacco? .... YES NO
16. Are you or have you ever been alcohol and/or drug dependent? .... YES NO
If yes, are you currently or have in the past ever received treatment? .... YES NO
17. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD: **CIRCLE ONE**

Condition			Condition		
A.I.D.S	YES	NO	Heart pacemaker	YES	NO
Anemia	YES	NO	Heart surgery	YES	NO
Angina pectoris	YES	NO	Hepatitis A/ B/ C	YES	NO
Arthritis/Rheumatism	YES	NO	Herpes/ Venereal disease	YES	NO
Artificial heart valve	YES	NO	High/Low blood pressure	YES	NO
Artificial joints(Hip,Knee)	YES	NO	Jaundice	YES	NO
Blood disorders	YES	NO	Kidney disease	YES	NO
Bronchitis	YES	NO	Liver disease	YES	NO
Cancer	YES	NO	Lung disease	YES	NO
Circulation problems	YES	NO	Lupus	YES	NO
Congenital heart lesions	YES	NO	Mental/nervous disorder	YES	NO
Cortisone/ Steroid	YES	NO	Medical transplant/implant	YES	NO
Crohn's Disease	YES	NO	Psychiatric treatment	YES	NO
Diabetes	YES	NO	Scarlet/ rheumatic fever	YES	NO
Emphysema	YES	NO	Sickle cell disease	YES	NO
Epilepsy or seizures	YES	NO	Sinus trouble	YES	NO
Fainting or dizzy spells	YES	NO	Stomach/intestinal problems	YES	NO
Glandular disorders	YES	NO	Stroke	YES	NO
Glaucoma	YES	NO	Thyroid disease	YES	NO
Heart disease or attack	YES	NO	Tuberculosis	YES	NO
Heart murmur	YES	NO	Other ___________________		

18. Do you currently have, or have had in the past, any disease, condition or problem not listed above? YES NO
If yes, please specify. ____
19. **Women only:** Are you Pregnant? YES NO If yes, expected due date _____________

I, the undersigned, certify that I have provided an accurate and complete personal and 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 my medical/dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary. I understand that responsibility for payment for the dental services for myself or my dependents is mine, and I will assure responsibility for fees associated with these services.

SIGNATURE: ______________________________**PRINT NAME:** ____________________ **DATE:** ___________________
Patient ☐ Parent ☐ Guardian ☐

MEDICAL HISTORY UPDATE: (IF ANY CHANGES TO MEDICAL HISTORY, PATIENT TO SIGN AND DATE BELOW)
Date_________ Patient Signature_______________________ Date________ Patient Signature_______________________

Date_________ Patient Signature_______________________ Date________ Patient Signature_______________________