**Medical Dental History**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Province \_\_\_\_\_\_\_\_\_\_ Postal Code \_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Opt-In to receive important communications from Sherwood Dental. I can change my preferences at any time

**How did you hear about us? (Please check one):**  Google  Facebook Yellow Pages  Word of mouth  Friend/Family

**Whom may we thank for your referral?** Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently under the care of a physician? **Yes / No** If so, explain:

Are you taking any drugs or medication at this time?

Drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had any adverse effect to any of the following (please check if yes):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Penicillin | * Sulfa | * Barbiturates (sleeping pills) | * Valium | * Erythromycin |
| * Codeine | * Aspirin | * Local Anaesthetic | * Nitrous Oxide |  |

Have you ever been warned against using any other medications: **Yes / No**  Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious illness or operation / or have you ever been hospitalized? **Yes / No** Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from any allergies? (hay fever, latex, penicillin etc.) **Yes / No**  Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you bruise easily or have prolonged bleeding? **Yes / No** Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? **Yes/ No** How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you ever faint, have shortness of breath or chest pain? **Yes / No** Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

-WOMEN- Are you pregnant? **Yes / No** How many weeks? \_\_\_\_\_\_\_\_\_\_ Are you using birth control? **Yes / No**

Do you have or have you ever had the following? (please check if yes)

|  |  |  |  |
| --- | --- | --- | --- |
| * Heart disease/attack | * High/Low blood pressure | * Radiation/Chemotherapy | * Leukemia |
| * Angina pectoris | * Diabetes | * Cancer | * Lung Disease |
| * Heart pacemaker/surgery | * Kidney disease | * Anemia | * Tuberculosis |
| * Artificial heart valve | * Emphysema | * Bronchitis | * Venereal disease |
| * Heart murmur | * Epilepsy | * Stroke |  A.I.D.S. / H.I.V. |
| * Artificial joint (hip/knee) | * Glandular disorders | * Thyroid disease | * Hepatitis A B C |
| * Congenital heart lesions | * Glaucoma | * Mental/nervous disorder | * Herpes |
| * Rheumatic/Scarlet fever | * Asthma | * Liver disease | * Other |
| * Mitral valve prolapse | * Blood disorders | * Arthritis | * Migraines |

Do you have any disease or problem not listed above you think I should know about? **Yes / No**

**Dental History**

What is the reason for today’s visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How frequently do you see a dentist?  3-6 months  Annually  Other

When was your last dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last dental x-ray? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had tooth brushing or flossing instruction? **Yes / No**

Have you ever noticed any sign of periodontal disease? **Yes / No** Bleeding gums? **Yes / No**

Swelling of gums? **Yes / No** Gum ache? **Yes / No** Receding gums? **Yes / No** Loose teeth? **Yes / No**

Bad breath? **Yes / No** Does your jaw pop, crack or grate when you open your mouth? **Yes / No**

Do you grind your teeth? **Yes / No** Do you tend to catch food between your teeth? **Yes / No**

Have you ever had any problems with previous dental treatments? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with the way your teeth feel? **Yes / No** Are you satisfied with way your teeth function? **Yes / No**

What, if anything, would you like to change about your smile? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Consent for Treatment

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated. I fully understand the office policy and will assume responsibility for fees associated with those procedures performed. I also consent to the use of my email address (when provided above) and emailing to communicate with myself, my insurance company, dental offices or specialists in the sending of receipts, statements, estimates, x-rays and any information requested by such for the process of predeterminations, claims or updating records.

**Patient/Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- |
| **Date** | **Med. History Changes** | **Initials** |
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