Patient Medical History and Consent Form

Sparrow Dental

Patient Name:

Address: Unit No. Street

Town / City Province Post Code

How did you find out about our clinic?

- ◯ Friend / Relative *Name:*
- ◯ Flyer
- ◯ Road sign
- ◯ Other

Personal Information

Patient info

Sex: ◯male ◯female Date of birth:

◯Single ◯Married ◯Window ◯Separated ◯Divorced

Home Work

Email:

Occupation:

Empolyer:

If student: ◯PT ◯FT

A person responsible for account

Sex: ◯male ◯female Date of birth:

◯Single ◯Married ◯Window ◯Separated ◯Divorced

Home Work

Email:

Occupation:

Empolyer:

If student: ◯PT ◯FT

Insurance Information

	Primary Insurance	Secondary Insurance (if applicable)
Policy Holder's Name		
Relationship to Patient		
Date of birth		
Name of Employer		
Employee Address		
Insurance Co.		
Group #		
Certificate ID		

Dental History

Previous dentist's name

Last dental exam date

Physician's name

Last physical exam date

Are you in pain or discomfort at this time?	◯YES ◯NO
Is there anything you dislike about your smile?	◯YES ◯NO
Do you feel nervous about having dental treatment?	◯YES ◯NO
Ever had a bad experience in a dental office?	◯YES ◯NO
Have you been seen by us before?	◯YES ◯NO
Anything you'd like to tell the dentist in private?	◯YES ◯NO

Please list any family members seen by us before:

Have you ever experienced any of the following problems with your jaw? **Check all that apply**

◯ Anemia ◯ Clicking ◯ Pain in or around your ears ◯ Difficulty opening or closing ◯ Difficulty chewing
◯ History of the face or jaw trauma ◯ Diagnosed with TMJ/TMD ◯ Habitual clenching/grinding during day or night

Do you currently have any of the problems listed below?

◯ Swelling ◯ Bad breath ◯ Bleeding gum ◯ Loose teeth ◯ Bad taste ◯ Sores/lumps/growths in or near the mouth
◯ Food collecting between your teeth

Are you sensitive to any of the following?

◯ Hot ◯ Cold ◯ Biting/Pressure ◯ Sweets ◯ Other

Ever had difficult extractions in the past?	◯ YES ◯ NO
Ever had prolonged bleeding after extractions?	◯ YES ◯ NO
Ever been told you have gum problems?	◯ YES ◯ NO
Ever needed to see a periodontist?	◯ YES ◯ NO
Ever taken Redux or Pondimin (Fen-Phen)?	◯ YES ◯ NO
Ever had instructions on oral hygiene?	◯ YES ◯ NO

Allergy and Medication History

Do you have an allergic reaction to any medication or substance? **Select all that apply**

◯ Aspirin ◯ Barbiturates ◯ Codein ◯ Iodine ◯ Latex ◯ Local anesthetic ◯ Penicillin ◯ Sulfa ◯ Metals
◯ Other

Are you currently taking any medications, vitamins, herbal supplements or cures ***Request another sheet if necessary***

Drug	Purpose	Drug	Purpose

Medical History

Place a mark on yes or no to indicate if you have had any of the following

◯ YES ◯ No Chest Pain	◯ YES ◯ No Shortness of Breath	◯ YES ◯ No Hives or skin rash
◯ YES ◯ No Heart Failure	◯ YES ◯ No Ulcers	◯ YES ◯ No Glaucoma
◯ YES ◯ No Heart Disease or Attack	◯ YES ◯ No Mental Disability	◯ YES ◯ No *Steroid Treatment
◯ YES ◯ No Angina Pectoris	◯ YES ◯ No Emphysema	◯ YES ◯ No *Congenital Heart Problems
◯ YES ◯ No Heart Problems	◯ YES ◯ No Fainting or dizzy spells	◯ YES ◯ No *Any type of implant
◯ YES ◯ No Liver Disease	◯ YES ◯ No Eating Disorder	◯ YES ◯ No Dentures or Partials
◯ YES ◯ No Heart Surgery	◯ YES ◯ No Epilepsy or seizures	◯ YES ◯ No Birth defects
◯ YES ◯ No High Blood Pressure	◯ YES ◯ No Persistent Cough	◯ YES ◯ No HIV Positive, ARC, AIDS
◯ YES ◯ No *Heart Murmur	◯ YES ◯ No Tuberculosis (TB)	◯ YES ◯ No Hay fever
◯ YES ◯ No *Rheumatic Fever	◯ YES ◯ No Asthma	◯ YES ◯ No Bruise easily
◯ YES ◯ No Psychiatric treatment	◯ YES ◯ No Hepatitis A	◯ YES ◯ No Jaundice
◯ YES ◯ No Sickle Cell Disease	◯ YES ◯ No Hepatitis B	◯ YES ◯ No Any Type of Surgery
◯ YES ◯ No Sinus trouble	◯ YES ◯ No Hepatitis C or other	◯ YES ◯ No Kidney Trouble
◯ YES ◯ No *Artificial joints	◯ YES ◯ No Heart pacemaker	◯ YES ◯ No Radiation Therapy
◯ YES ◯ No Thyroid Disease	◯ YES ◯ No Cold Sores	◯ YES ◯ No Chemotherapy
◯ YES ◯ No Anemia	◯ YES ◯ No Stroke	◯ YES ◯ No Cancer type:
◯ YES ◯ No Blood transfusion	◯ YES ◯ No Herpes	◯ YES ◯ No Hospitalization (past 2 yrs)
◯ YES ◯ No *Any type of transplant	◯ YES ◯ No Arthritis	◯ YES ◯ No Under medical doctor's care (past 2 yrs)
◯ YES ◯ No *Mitral Valve Prolapse	◯ YES ◯ No Drug addiction	◯ YES ◯ No Women: Pregnant? Months:
◯ YES ◯ No Diabetes	◯ YES ◯ No Alcoholism	◯ YES ◯ No Women: On birth control pills?
◯ YES ◯ No Hemophilia	◯ YES ◯ No Use of tobacco products	◯ YES ◯ No Women: Breastfeeding?

*Antibiotic premedication may be required prior to your appointment.

Emergency

Emergency contact name	Relationship to Patient	Emergency Contact Number

If there is anything related to your medical or dental history not indicated above, please explain:

Medical/dental history. I have answered the above questions to the best of my knowledge. I understand that providing wrong information can be dangerous to my health. I will notify the dentist of any change in my medical/dental history. I have been given the chance to ask questions and receive answers to any questions regarding my dental/medical history.

Disclosure. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize the dentist to perform the diagnostic procedure required to determine the necessary treatment. I understand that consultation with my medical doctor may be required. I understand that the privacy policy of the office reflects that of the Royal College of Dental Surgeons of Ontario and that my personal information will be collected, used and disclosed within the guidelines of that policy.

Contact info. I authorize the office to use my contact information to send me invoices for dental services and reminders (including via email and text message) concerning upcoming appointments. I will notify the office of any change in my contact information.

Financial and insurance. I understand that the responsibility for payment of dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services. I understand that my dental insurance carrier may pay less than the actual bill for services. **I understand that if payment for services is sent to insurance and cannot be collected, is declined, or is not covered, the charge will be transferred to my account and payment for services will be my responsibility.** I understand that if payment from my insurance cannot be collected within a period of 30 days of treatment, the charges will be transferred to my account and I will be responsible for paying for the treatment rendered and further coordinating with my insurance for reimbursement. I am aware that insurance predeterminations are done as a courtesy service by the dental office and that responsibility for ensuring insurance coverage prior to treatment rests solely on me. I understand that payment is due upon treatment completion. Should the assignment be accepted by the dentist, I authorize and request that my insurance company pay directly to the dentist insurance benefits otherwise payable to me.

Cancellations and missed appointments. I understand that my appointment is time specifically reserved for me. I, therefore, understand that a 48-hour notice is required for the cancellation of a scheduled appointment to avoid a $50 cancellation fee.

Patient / Guardian Signature: _____ **Date**

Dentist Signature: _____ **Date**

Submit Form