YORK LANES DENTAL OFFICE

Welcome to YORK LANES DENTAL OFFICE

A parent or guardian will be responsible for decisions on my treatment ? YES ☐ NO ☐

The Information that is requested on the questionnaire 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. We are committed to collecting, using and disclosing this information responsibly.

MEDICAL ALERT

Name: First	Initial	Last		
Address 1: Street (Main Address)	Apt.	City	Province	Postal Code
Email Address:	Birth Date: MONTH DAY YEAR		AGE SEX	MARITAL STATUS
Home #	Work #		Cell #	
Family Physician's Name:	Tel #		Emergency Contact Name:	
Address			Relationship:	
Are you under the care of a Medical Specialist? YES ☐ NO ☐			Emergency Contact #:	

HEALTH HISTORY

PLEASE √ YES OR NO TO EACH QUESTION.

YES	No		
☐	☐	1.	Have you ever been hospitalized? Specify: _____
☐	☐	2.	Are you presently under the care of a physician? Specify: _____
☐	☐	3.	Are you currently on any medication? Specify: _____
☐	☐	4.	Do you have any allergic conditions? Specify: _____
☐	☐	5.	Are you allergic to any drugs or medication? Specify: _____
☐	☐	6.	Have you been warned against any medication? Specify: _____
☐	☐	7.	Do you bleed or bruise easily? Specify: _____
☐	☐	8.	Have you had any organ transplants/implants? Specify: _____
☐	☐	9.	Have you ever fainted? Specify: _____
☐	☐	10.	Have you ever had an injury or surgery to the face or jaw? Specify: _____
☐	☐	11.	Have you had any weight changes recently? Specify: _____
☐	☐	12.	Do you have any conditions/diseases you should mention? Specify: _____
☐	☐	13.	WOMEN ONLY: Are you pregnant? If yes, which month, Specify: _____ Are you taking birth control pills? Specify: _____
☐	☐	14.	Do you smoke? What? _____ No. per day _____

Doctor Signature _____ Date _____

MEDICAL HISTORY continued on reverse side

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HEALTH HISTORY CONTINUED

PLEASE √ IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

Indicate which of the following you presently have, or ever had:

- ☐ Heart Problems/Heart Attack
- ☐ Heart Murmur/Rheumatic Fever
- ☐ High/ Low Blood Pressure
- ☐ Lung/Chest Problems
- ☐ Malignant Hypothermia
- ☐ Stomach/Intestinal Problems
- ☐ Sleep Apnea
- ☐ Diabetes/Hypoglycemia
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Hepatitis A/B/C
- ☐ TB (Tuberculosis)
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Stroke
- ☐ Jaundice
- ☐ Steroid Therapy
- ☐ HIV Positive / AIDS
- ☐ Pacemaker
- ☐ Other _____

DENTAL HISTORY

1. Date of your last dental visit? _____ Last cleaning? _____ Last X-Rays? _____
2. Reason for today's visit?
   - ☐ Specific Problem ☐ Emergency Exam ☐ Complete Exam ☐ Cleaning
   - ☐ Other _____

	YES	No
3. Have you ever had any problems, bad experience with a previous dentist or dental office?	☐	☐
If yes, please specify: _____		
4. Do you have frequent headaches/migraines?	☐	☐
Would you like information on treatment for this?	☐	☐
5. Are you concerned about your breath?	☐	☐
We have treatments available, would you be interested?	☐	☐
6. Are you interested in whitening your teeth?	☐	☐
Would you like information regarding whitening/bleaching your teeth?	☐	☐
7. Would you be interested in changing the appearance of your teeth?	☐	☐
What would you like to change if anything? _____		
8. Does your jaw crack, pop or grate when you open widely?	☐	☐
9. Do you grind or clench your teeth?	☐	☐
10. Do you have food catch between your teeth?	☐	☐

11. How do you rate your smile on a scale of 1-10 (ten being perfect) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

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. **Should there be any change in either my health status or any other information I have provided, I will advise York Lanes Dental Office.** I authorize the dentist to perform diagnostic procedures, dental treatment and surgical procedures as deemed necessary. I understand that information provided from or to my medical doctor or another health care provided may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependants is mine, and I assume responsibility for fees with these services.

Patient or Parent/Guardian Signature _____ Date _____