Allandale DENTAL CENTRE

Medical History Update

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☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Gender: _____

Address: _____ Apt./Unit #: _____

Province: _____ Postal Code: _____

Cellphone Number: _____ Home Number: _____

Work Number: _____ Ext: _____ Employer: _____

Email Address: _____

Emergency Contact – Please Notify (name & number): _____

May we send you emails/text notifications? ☐ Yes ☐ No

Please check any of the following that apply to your health status:

- ☐ Heart Condition
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery/Procedures
- ☐ Angina
- ☐ Mitral Valve Prolapse
- ☐ Congenital Heart Disease
- ☐ Pacemaker
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Infective Endocarditis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Drug/Alcohol/Tobacco Dependency
- ☐ General Anesthetic Complications
- ☐ Diabetes Type 1 or 2
- ☐ Hypoglycemia
- ☐ HIV Positive/Aids
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Hepatitis A/B/C
- ☐ Hemophilia
- ☐ Excessive Bleeding/Bruising
- ☐ Immune Deficiencies
- ☐ Eating Disorder
- ☐ Lupus
- ☐ Thyroid Disease
- ☐ Steroid Therapy
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Asthma
- ☐ Respiratory Conditions
- ☐ Tuberculosis
- ☐ Snoring/Sleep Apnea
- ☐ Dizziness/Fainting
- ☐ HPV
- ☐ Herpes/Cold Sores
- ☐ Stomach Ulcers
- ☐ Acid Reflux
- ☐ Intestinal/Stomach Problems
- ☐ Lung Disease
- ☐ Joint Replacement
  - Joint: _____
  - Date: _____
- ☐ Arthritis
- ☐ Above Average Weight Gain/Loss
- ☐ Osteoporosis
- ☐ Long-term Actonel/Fosamax Use
- ☐ Vision Impairment
- ☐ Hearing Impairment
- ☐ Physical Impairment
- ☐ Cognitive Impairment
- ☐ TMJ (jaw joint) Concerns
- ☐ Epilepsy/Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Mental Health Issues
- ☐ Cancer
  - Type: _____
  - Date: _____
  - Radiation: _____
  - Chemotherapy: _____
  - Surgery: _____

Authorization

To the best of my knowledge, all of the preceding information is true and correct.
If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Responsible Party Name: _____ Signature: _____

Patient Name (please print): _____ Signature: _____ Date: _____