LAIRD EGLINTON DENTAL

Medical/Dental History Form

Name: _____
Last Initial First Pref. Name

Address: _____
Street (apt#) City Postal Code

Home: ( ) _____Cell: ( ) _____Work: ( ) _____

Date of Birth: D D / M M / Y Y Y Y Email: _____

Emergency Contact: _____ Phone: ( ) _____

How did you hear about us (Please Circle)? Facebook Google Sign Referral Other _____

Health Card #: _____ Do you have dental insurance? Y N

If Yes complete the following….

Primary Insurance

Company: _____ Policy Holder: _____

Policy/Plan/Group: _____ Certificate/I.D.:_____

Policy holders Date of Birth: : D D / M M / Y Y Y Y Relation to Holder: _____

Secondary Insurance

Company: _____ Policy Holder: _____

Policy/Plan/Group: _____ Certificate/I.D.:_____

Policy holders Date of Birth: : D D / M M / Y Y Y Y Relation to Holder: _____

Health History

Has there been any change in your general health? ..... Y N

If YES please describe: _____

Are you being treated for any medical condition or have you been treated within the past 2 years? ..... Y N

If YES please describe: _____

Are you currently being treated by a physician for a specific condition? ..... Y N

If YES please describe: _____

Are your currently taking any medication? ..... Y N

Name of Medication/Condition	**Dose**

Do you bleed or bruise easily? ..... Y N

Have you ever been hospitalized? ..... Y N

If YES please describe: _____

Have you ever received general anesthesia? ..... Y N

Have you ever had an adverse reaction to local anesthetic? ..... Y N

Do you have any allergies to medications (*If YES please list)* ? ..... Y N

Do you have any other allergies (*If YES please list)*?..... Y N

Continued on reverse…….

Do you currently have any of the following conditions? **(Please circle)**

Heart Murmur	Osteoporosis	Osteopenia	Rheumatic Fever
Heart Valve Replacement	Asthma	COPD	Sleep Apnea
Artificial Joint Replacement	Hepatitis A/B/C/D	Thyroid Disease	Mental Illness
Diabetes Type 1 / Type2	AIDS/HIV	Herpes / Cold Sores	Emotional Problems
High Blood Pressure	Heart Attack	Angina	Glaucoma
Diaphragmatic Hernia	Atherosclerosis	Stroke	Cataract Surgery (When? _____)
Kidney Disease	Liver Disease	Drug/Alcohol Abuse	Vitroretinal Surgery (When? _____)
Cancer (Type_____)	Jaundice	ADHD	Hormone Replacement Therapy
Epilepsy	Pacemaker	Organ Transplant	Arthritis (Type_____)
Radiation Therapy	Steroid Therapy	Stress	Surgery to Head and Neck

Is there anything else the doctor needs to know regarding your medical health? ..... Y N

If YES please explain: _____

Do you smoke? (Circle please) Y N Quit Tobacco / Cigars / Chew / Other

Amount/day: _____ for how long? _____ Quit Date: _____

Females ONLY: Are you or could you be pregnant? ..... Y N

Are you currently breast-feeding ? ..... Y N

Dental History

Last Dental Visit (Please circle): less than 1 yr (how many months) ____ 1 yr over 1 yr (how many years) ____

Are you currently experiencing any pain or discomfort?..... Y N

Are any of your teeth sensitive to: ___ Cold? ___ Hot? ___Sweet? ___Biting?

If Yes, which teeth or areas? _____

Do you have difficulty chewing food or does food get stuck between your teeth? ..... Y N

Are you unhappy with the overall appearance of your teeth? _____ Y N

Have you ever had braces for straightening your teeth? ..... Y N

Have you ever had an injury to your jaw or face? ..... Y N

Does your jaw ever click or pop or cause pain upon opening or closing? ..... Y N

Are you nervous during dental treatment? (If yes state *reason*)_____ Y N

PATIENT CERTIFICATION AND CONSENT

I the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policies posted in the reception area and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and determination of benefits. Unless other arrangements have been made assignment of benefits from your insurance company will be set up. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and my dentist. I authorize the dentist to treat me and I assume full responsibility for all fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

_____ _____

SIGNATURE (PARENT OR GUARDIAN IF UNDER 16) DATE

_____ _____

DENTIST'S SIGNATURE DATE