Medical Health Questionnaire

Patient Name: ____ **Date of Birth:** ____________ __(day/month/year)

MailingAddress____City________________________________

Postal Code________________________ **Email**: ____

Phone: (Home) ______________________ (Work) ______________________ (Cell) ______________________

Where is the best place to reach you during the day? (**Please circle) 1ST: Hm#, Cell#, Wk#, 2nd Hm#, Cell#, Wk#**

Family Dentist's Name: _______________________________

Phone:____

Family Doctor's Name: ________________________________ **Phone**:____

Emergency Contact: Name: ____ Phone: -

____

Are you currently under a physician's care now? ☐ No ☐ Yes, for____

Have you ever been hospitalized or had surgery in the past two years? ☐ No ☐ Yes, for__________________________________

Have you ever had a serious illness? ☐ No ☐ Yes If yes, what?____

Please list all pills, medications, herbs, and drugs that have been prescribed for you and ALL others that you take:

____

____

Are you taking any bisphosphonate or bone sparing drugs? (Fosamax, Actonel, Boniva, Didronel) ☐ No ☐ Yes

Do you have any allergies or reactions to drugs/medications, anesthetics, latex, or certain metals? ☐ No ☐ Yes:

If yes, please list all

____

Do you: Use tobacco? ☐ No ☐ Yes _________ /day Drink alcoholic beverages? ☐ No ☐ Yes amount/day__________

Women: Are you: Pregnant/Possibly Pregnant? ☐ No ☐ Yes Breastfeeding? ☐ No ☐ Yes Taking birth control pills? ☐ No ☐ Yes

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- o Adrenal Disease
- o AIDS/HIV+/ARC
- o Alzheimer's
- o Anaphylaxis
- o Anemia
- o Angina
- ☐ Arthritis
- o Artificial Joints
- o Artificial Valves
- o Asthma
- o Blood Disease
- o Bruise Easily
- o Cancer
- o Chemotherapy
- o Chest Pain
- o Cold Sores
- ☐ Congenital Heart Lesions
- ☐ Convulsion
- ☐ Cortisone/Steroids
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Emphysema
- ☐ Endocarditis
- ☐ Enlarged Heart
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Abnormality
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Problems
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives/Rash
- ☐ Immunosupression
- ☐ Intestinal Disease
- ☐ Irregular Heart Beat
- ☐ Jaundice
- ☐ Joint Pain/Swelling
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Mental Difficulties
- ☐ Neck/Back Pain
- ☐ Parathyroid Disease
- ☐ Persistent Cough
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ Problems
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers

Have you ever been directed to take antibiotics prior to any dental treatment? ☐ No ☐ Yes

Do you have any problem, condition or disease not listed above? ☐ No ☐ Yes If so, what?

____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that withholding or providing incorrect information may be dangerous to my (or the patient's) health. I also agree to inform the doctor and/or staff of any changes in my (or the patient's) medical status.

I understand that I am responsible for all fees. I further understand that failing to provide two full business days notice to cancel or change an appointment may result in a cancellation fee. **Sign and date below**

Signature: ___________________________________ Date : _____________________
Signature of Patient, Parent or Legal Guardian

DENTAL HEALTH SPECIALISTS

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL HEALTH INFORMATION

In accordance with PIPEDA (Personal Information Protection and Electronic Documents Act)

I authorize Imperio Group Dental Health Specialists to collect personal information relating to my dental and medical health. I understand this information is required to allow for proper evaluation, diagnosis and treatment of oral and dental health conditions.

I consent to the communication of information to my referring dentist, other dental specialists, my physician(s), dental laboratories; my dental benefits plan administrator, insurance carrier, and the Canadian Dental Association, when necessary. The information may be transferred to the necessary individuals via phone, mail, fax or internet.

This information may include clinical records, x-rays, diagnostic models, general health information obtained from a medical history review, insurance information, phone numbers, addresses and photographs of my teeth / mouth / smile / face. Clinical information, photographs and x-rays may also be used for long-term follow-up and research, as well as for education or teaching purposes.

Imperio Group Dental Health Specialists recognizes the importance of personal information protection and makes every effort possible to safeguard this information.

To avoid short notice cancellation fees I will provide the office a week notice for any rescheding of surgeries and 2 business days notice for any exams and cleanings.

I hereby certify that I have read and understand this document.

____________________________ ____
Date Print Name

____ Signature of Patient or Guardian