



Medical & Dental History

Uplands Dental Clinic - Dr.Haslam & Dr.Leigh

Patient Information

Title	Patient Name	Date of Birth	Age	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other
Address (street name, unit #)		City	Province	Postal Code
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Primary Phone	Secondary Phone	Email Address		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Preferred contact method	Family Physician Name	Physician Phone		
<input type="radio"/> Phone <input type="radio"/> Email	<input type="text"/>	<input type="text"/>		
Emergency Contact	Primary Phone	Relationship		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

Medical Information

Do you have or have you ever had any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Auto-Immune Diseases | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prosthetic Heart Valve |
| <input type="checkbox"/> Cancer (specify below) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiotherapy |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Insulin | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Crohn's/IBS | <input type="checkbox"/> Joint Replacement (specify date below) | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Epilepsy - Seizures | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Esophageal Re-flux (GERD) | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumours (specify below) |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Transplants (specify below) |

Please specify any additional details to supplement the previous section

Please list any medications/supplements being taken (attach a list if multiple)

Please list any known allergies

Please list any hospitalizations in the past 2 years

Please list any surgeries

Please list any recreational substances you take and frequency

Do you suffer from, or have a family history of malignant hyperthermia

☐ Yes ☐ No

Are you taking blood thinners?

☐ Yes ☐ No

Do you have problems with your bleeding time?

☐ Yes ☐ No

WOMEN ONLY - Are you pregnant? If yes, how many months?

☐ Yes ☐ No

WOMEN ONLY - Are you nursing?

☐ Yes ☐ No

Dental Information

When was your last dental visit?

What was the reason for your visit?

Are you having any problems that require immediate attention?

Are you nervous during dental treatment?

☐ Yes ☐ No

Do you currently have or have you ever had any of the following? Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Bleeding gums when you brush your teeth | <input type="checkbox"/> Periodontal Treatment |
| <input type="checkbox"/> Clenching/Grinding | <input type="checkbox"/> Swelling of the face/neck |
| <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Temperature Sensitivity |
| <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Tooth Pain |

Are you interested in any of the following? Check all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Bridge/Dentures | <input type="checkbox"/> Dental Crowns | <input type="checkbox"/> Dental Implants |
| <input type="checkbox"/> Straightening Teeth | <input type="checkbox"/> Teeth Whitening | |

Cancellations and Missed Appointments

Your appointment time has been exclusively for you to see the dentist or hygienist. We ask that you give us at least 48 hours advance notice when cancelling your scheduled appointment so that we may offer the time to another patient.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal, medical and 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 and dental history. Should there be any change in either my health status or any other information I have provided I will advise this dental office. I understand that information provided from or to my medical doctor or healthcare provider 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 my dental insurance may not cover entirely the total fee of services provided. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Signature (patient/guardian)

Dentist Signature

Date: _____

Date: _____