FUNDY DENTAL CENTRE

PATIENT INFORMATION

Name: _____ Birth Date: _____-_____-_____
DAY MONTH YEAR

Address: _____ Health Card # _____

Town: _____ Prov: _____ Postal Code:_____

Home Ph: (_____)_____ Cell Ph: (_____)_____

Emergency Contact: _____Relationship:_____ Ph: (_____)_____

DENTAL COVERAGE

Please provide your dental coverage details to the reception staff.

- I have coverage through the government: Social Assistance | Special Needs | MSI | NIHB | VA | CDCP
- I have private dental insurance: Yes | No | I also have a secondary insurance plan: Yes | No

FAMILY DENTIST

Dentist's Name: _____ Town: _____

- *I consent for this office to send clinical notes/x-rays to my dentist (even if I don't currently have one).* Yes | No

MEDICAL HISTORY

CURRENT MEDICATIONS: *List them all below, or provide a list to reception staff.*		**ALLERGIES TO MEDICATIONS:**
☐ ***I consent*** for you to contact my pharmacy to acquire my current prescriptions list. Pharmacy:	Town:	-
-	-	-
-	-	-
-	-	-

- Medical conditions that I am *currently* being treated for: _____

_____

- I have a history or present condition, as follows: *(check all that apply)*

☐ I require pre-medication *(due to joint or heart disease)* ☐ I am on Bisphosphonate drugs ☐ Currently Pregnant

☐ Cancer: Type _____ Active: Y | N ☐ Radiation Treatment ☐ Chemotherapy

☐ Smoke / Vape ☐ Asthma / COPD / *other* ☐ High Blood Pressure ☐ Diabetes

☐ Heart Attack ☐ Stroke ☐ Heart Surgery ☐ Heart Condition

☐ Drug Abuse ☐ Liver / Kidney Issues ☐ Prolonged Bleeding / Bleeding Disorder _____

☐ Psychiatric Treatment ☐ Hive ☐ Migraines ☐ Infectious diseases: STD / HIV / AIDS / HEP C / *Other*

☐ *Other Conditions*: _____

- **FAMILY HISTORY**: Health Conditions, re: Heart / Lung / Bleeding / Cancer : _____

To the best of my knowledge, all preceding answers are true and complete. I agree to inform my dentist of any health or medication changes.

Signed: _____ Date: _____

Please review our Privacy Statement & Office Policies sign in the waiting area.