Medical Alerts:_____

KLIMITZ DENTAL

28 Via Bagnato
North york, Ontario
M6A-0B4
416-783-5419

Medical & Dental History Form

Patient Last Name: _____ Given Name: _____ Nickname:_____ Parents:_____

Date of Birth: ___ / ___ / _____ Age: ____ Sex: ____ Occupation: _____
MM DD YYYY

Address: _____ Postal Code: _____

Home #: _____ Work #:_____ Cell #:_____ Email: _____

Family Physician:_____ Physician's #: _____

Dental Insurance Coverage ☐Y ☐N Policy Name :_____ Plan#:_____ Plan ID: _____

Credit Card Type: _____ Credit Card #: _____ Exp ___/ _____

Emergency Contact Information : Name: _____ Phone #: _____

Referral Information: How did you hear about KlimitzDental?

☐Friends/Family _____☐Internet ☐ Walked past office ☐ Other: _____

MEDICAL HISTORY

Are you under the routine care of a family physician? ☐Y ☐N
If yes, when was your last physical? Were there any changes in your general health? _____

Have you had any serious illness, operation or been hospitalized in the past 2 years? ☐Y ☐N

If yes, please elaborate: _____

Do you have any **Allergies?** ☐Y ☐N If yes, please answer below**:**

☐Local Anesthetic/"Freezing"	☐Antibiotics (Penicillin,Tetracycline, etc.)	☐Sulfa Drugs
☐Codeine or other Narcotics	☐Aspirin	☐Latex
☐Barbiturates or Sedatives	☐Other: _____	

Allergies continued: _____

Are you taking any medications, non-prescription drugs or herbal supplements? ☐Y ☐N
Please list:

Drug Name	*Dosage*	*Frequency*	*Indication*

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5. Have you ever had any of the following? Please tick those that apply:

☐Heart Surgery (heart transplant, artificial valve repair or replacement, etc.)	☐Breathing Problems (asthma, Bronchitis, Emphysema, etc.)	☐Heart Condition (Congenital heart disease)
☐Heart Infection (Endocarditis, etc.)	☐AIDS or HIV infection	☐Anemia or Blood Disease
☐Kidney Disease	☐Hepatitis A,B,C	☐Epilepsy/Seizures
☐Blood Pressure Problems	☐Diabetes (Type I or Type II)	☐Cancer
☐Angina/Chest Pain	☐Tuberculosis	☐Stroke
☐Steroid or Radiation Therapy	☐Thyroid Problems	☐Pacemaker
☐Excessive Bleeding or Bruising	☐Heart Murmur	☐Rheumatic Fever
☐Liver Disease or Jaundice	☐Osteoporosis	☐Artificial Joints
☐Psychological Disorder	☐Stomach Ulcers/GERD	☐Other not listed: _____

Additional existing health conditions: _____

6. Is it possible you are pregnant? Are you nursing?☐Y☐N If pregnant, how many months?_____

7. Do you smoke or chew tobacco products?☐Y☐N If yes, how frequently? _____

8. Do you have a history of drug or alcohol dependency?☐Y☐N _____

DENTAL HISTORY

1. What is the main purpose of your visit today? _____
2. When was your last dental check-up? _____
3. If you have gone for routine dental care in the past, who was your dentist? _____
4. Have you ever seen a specialist (Oral surgeon, Periodontist, etc.)? _____
5. Have you ever had any unusual difficulties with previous dental treatment?☐Y☐N . If so please explain: _____
6. Do you brush your teeth?☐Y☐N If yes, how frequently: _____
7. Do you floss your teeth?☐Y☐N f lyes, how frequently: _____
8. Does dental treatment make you nervous? ☐No☐Slightly ☐Moderately ☐Extremely
9. Have you ever had or require the following for dental treatment?

☐Nitrous Oxide (laughing gas)☐Oral Sedation ☐Intravenous Sedation☐ General Anesthesia

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CONSENT FOR SERVICES

- I certify that I have read and understand the above. I acknowledge that the above has been answered to my satisfaction. I will not hold my dentist, or any other staff member, responsible for any errors or omissions that I may have made in the completion of this form.
- The appointment time is reserved for you. If you are unable to keep this appointment, please notify us two working days in advance, in which case no charge will be made.

_____ _____ _____

Print Name ☐Patient/☐Parent / ☐Guardian Signature Date