Jain Dental Care Welcome to our office. Please fill out your MEDICAL HISTORY FORM

NAME: MR. / MRS. / MISS / MS. / DR.

DATE OF BIRTH (DAY/MONTH/YEAR):

ADDRESS (HOME):

HOME PHONE:

EMPLOYER:

OCCUPATION:

WORK PHONE:

EMAIL:

MOBILE PHONE:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

1.NAME OF MEDICAL SPECIALIST:

PHONE:

2. NAME OF MEDICAL SPECIALIST:

PHONE:

DATE OF LAST DENTAL VISIT:

REASON FOR TODAY'S VISIT:

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
❑Y E S ❑ N O ❑ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain. ❑Y E S ❑ N O ❑ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ❑Y E S ❑ N O ❑ NOT SURE/MAYBE
If yes, please list medication and reason why it is taken. (We can photocopy your medication list if necessary)

Medication	Reason	Medication	Reason

5. Do you have any allergies? If you answered yes, please list using the categories below: ❑Y E S ❑ N O ❑ NOT SURE/MAYBE
a) Medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
❑Y E S ❑ N O ❑ NOT SURE/MAYBE

7. Do you have or have you ever had asthma? ❑Y E S ❑ N O ❑ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ❑YES ❑NO ❑NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ❑YES ❑NO ❑NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ❑YES ❑NO ❑NOT SURE/MAYBE

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE…

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ❑YES ❑NO ❑NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ❑YES ❑NO ❑NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ❑YES ❑NO ❑NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ❑YES ❑NO ❑NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

❑ chest pain, angina	❑ rheumatic fever	❑ pacemaker	❑ steroid therapy	❑ seizures (epilepsy)	❑ osteoporosis medications (e.g. Fosamax, Actonel)
❑ heart attack	❑ mitral valve prolapse	❑ lung disease	❑ diabetes	❑ kidney disease	
❑ stroke		❑ tuberculosis	❑ GI ulcers	❑ thyroid disease	
❑ shortness of breath	❑ heart murmur	❑ cancer	❑ arthritis	❑ drug/alcohol dependency	

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ❑ YES ❑NO ❑NOT SURE/MAYBE

17. Do you smoke or chew tobacco products? # per day for # years ❑YES ❑NO ❑NOT SURE/MAYBE

18. Are you nervous during dental treatment? ❑YES ❑NO ❑NOT SURE/MAYBE

19. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ❑YES ❑NO ❑NOT SURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

PERSONAL HEALTH INFORMATION PROTECTION ACT

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance. Your personal health information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA. You may withdraw your consent for use or disclosure of your personal health information at any time.

Patient Consent

I have reviewed the above information that explains how your office will use my personal health information, and the steps your office is taking to protect my information. I agree that Maneesh Jain Dentistry Professional Corporation operating as **Jain Dental Care** can collect, use and disclose personal health information as set out above in the information about the office's privacy policies.

Date _____ Signature _____

Print name _____ Signature of witness_____