Medical History Update

First Name:_____ Last Name: _____ Preferred Name: _____

Address: _____ Apt/Unit#:_____

City: _____ Province:_____ Postal Code: _____

Home Phone: _____ Cell: _____ Work: _____ ext: _____

Date of Birth: _____ (mm/dd/yyyy) E-mail address: _____

Family Physician: _____ Phone Number: _____

Pharmacy Name: _____ Phone Number: _____

May we send you emails about important office notifications, including appointment reminders? □ Yes □ No

May we send you text message appointment reminders? □ Yes □ No

You have the option to withdraw your consent at any time.

Please check any PAST or PRESENT medical conditions

□ *Heart condition*
□ *Angina*
□ *Heart surgery/procedures*
□ *Heart attack*
□ *Stroke/T.I.A*
□ *Heart murmur*
□ *Mitral valve prolapse*
□ *Congenital heart disease*
□ *Infective Endocarditis*
□ *Pacemaker*
□ *High blood pressure*
□ *Low blood pressure*
□ *General Anesthetic complications*
□ *Diabetes: Type I or II*
□ *Hypoglycemia*

□ *HIV positive/AIDS*
□ *Anemia*
□ *Blood disorders*
□ *Hepatitis A/B/C*
□ *Hemophilia*
□ *Excessive bleeding/bruising*
□ *Immunedeficiencies*
□ *Eating disorder*
□ *Lupus*
□ *Thyroid disease*
□ *Kidney disease*
□ *Liver disease*
□ *Joint replacement*
joint _____
date _____

□ *Cancer - type:* _____
Date
Radiation:
Chemotherapy:
Surgery
□ *Asthma*
□ *Respiratory conditions*
□ *Tuberculosis*
□ *Snoring/sleep apnea*
□ *Dizziness/fainting*
□ *HPV*
□ *Herpes/cold sores*
□ *Ulcers/acid reflux*
□ *Intestinal/stomach problems*
□ *Above average weight gain/loss*

□ *Vision Impairment*
□ *Hearing impairment*
□ *TMJ (jaw joint) concerns*
□ *Physical impairment*
□ *Arthritis*
□ *Osteoporosis*
□ *Long-term Actonel/Fosomax use*
□ *Epilepsy/seizures*
□ *Cognitive impairment*
□ *Depression*
□ *Anxiety*
□ *Mental health issues*
□ *Drug/alcohol dependency*
□ *Tobacco Use*
□ *Other*_____

Do you have any allergies or sensitivities to: Medication: _____
Food: _____
Environment: _____

Are you pregnant? No □ Possibly □ Yes □ If so, how many weeks:

Have you had any surgery in the past or coming up in the near future: No □ Yes □

Explain: _____

Is there anything else to report about your health not listed above? _____

List ALL current medications including prescription, herbal/naturopathic or over the counter MEDICATIONS:

_____

Information for our Patients

At Dawson Dental Centre, all professional dental services are performed by licensed members of the Royal College of Dental Surgeons ("Dental Professionals"), and all institutional health care services are performed independently by Dawson Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Dawson Dental Centre and Dawson Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Dawson Health Services.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Dawson Dental Centre; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Dawson Dental Centre to provide the services you are requesting).

I, the undersigned, certify that I have provided and accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – 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. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Dawson Dental Centre, Dawson Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Dawson Dental Centre and Dawson Health Services in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Dawson Dental Centre and Dawson Health Services are relying upon the information which I have provided being accurate and complete.

Patient Signature: _____ □ Patient □ Parent □ Guardian Date: _____

Dentist Signature: _____ Date: _____

DAWSON DENTAL CENTRE