Mavis Dental Centre

Date: ____/____/____ **PATIENT INFORMATION**
M D Y

PATIENT IS AN: ADULT ☐ CHILD ☐ NAME OF PARENT/GUARDIAN: _____

Name: _____ Mrs. ☐ Ms. ☐ Mr. ☐
(last) (first) (middle)

Home: _____
(street) (city) (province) (postal code)

Home Phone: (____)_____ Cell Phone: (____)_____ Business Phone: (____)_____

E-mail: _____@_____

Date of Birth: _____/_____/_____ Age: _____ Sex: _____ Marital Status: _____
M D Y

OCCUPATION: _____

Employed By: _____ Phone: (____)_____ Ext: _____

Spouse Employed By: _____ Phone: (____)_____ Ext: _____

MEDICAL OFFICE:

Family Physician: _____ Phone: (____)_____

Medical Specialist: _____ Phone: (____)_____

PERSON RESPONSIBLE FOR ACCOUNT: SELF ☐ OTHER ☐ ➡ Name:_____

Address: _____ E-mail: _____

Home Phone: (____)_____ Business Phone: (____)_____ Cell Phone: (____)_____

IN CASE OF EMERGENCY: Please Notify: _____ Relationship: _____

Home Phone: (____)_____ Business Phone: (____)_____ Cell Phone: (____)_____

Is any other member of your family or relative a patient at our office?

REASON FOR TODAY'S VISIT: Examination ☐ Emergency ☐ OTHER ☐ _____

Who may we thank for referring you to our office?

MEDICAL HISTORY: Please check YES or NO. *If NOT SURE, Check NS.*	NO	NS	YES	
Are you presently under Doctor's care? Why?				
Have you been under Doctors care in the past two years? Why?				
Have you taken any medications, pills or drugs in the past two years?				
Are you presently taking any medications, pills or drugs?				*If **Yes**, list them here:*
Are you presently taking any Natural Supplements? (Vitamins or Herbal Remedies)				
Have you ever had Tonsillitis?				
Have you ever been hospitalized in the pas two yeas? (If yes why?)				
Have you had any type of surgery? When & Why?				
When was your last complete physical examination?				
Have you ever had pain is your chest or shortness of breath?				
Have you ever been diagnosed as having a tumor or cancer? When & Where.				
Have you ever taken cortisone/steroid medication?				
Do you experience problems with healing?				
Do you bruise easily or bleed excessively?				

MEDICAL HISTORY

MEDICAL ALERT	CONDITION	PREMEDICATION	ALLERGIES

ALLERGIES	Please check any medications you are allergic to or have reacted adversely to:				
☐ Penicillin	☐ Sulpha drugs	☐ Tylenol	☐ Naproxen	☐ Percocet	☐ Nitrous Oxide
☐ Amoxicillin	☐ Chlorhexidene (Peridex)	☐ Tylenol #2, #3, #4	☐ Toradol	☐ Darvon	☐ Latex
☐ Tetracycline	☐ Aspirin	☐ 222, 282, 292	☐ Demerol	☐ Valium	☐ Metal
☐ Clindamycin	☐ Ibuprofen (Advil)	☐ Codeine	☐ Percodan	☐ Ativan	
☐ Food allergies, please list: _____					
☐ Other: _____					

MEDICAL CONDITIONS	Please check all the following conditions you presently have, or have had. *If NOT SURE, Check NS.*									
	NO	NS	YES		NO	NS	YES		No	NS	YES
Chest Pain/Angina				Kidney Disease				Gout			
Heart Attack				Liver Disease				Psychiatric Care			
Stroke				Jaundice				Nervous Problems			
High Blood Pressure/ Hypertension				Thyroid Disease				Anemia			
Low blood Pressure				Lung Disease				Blood Disorders			
Heart Failure				Tuberculosis				Sickle Cell Anemia			
Rheumatic Fever				Asthma				Epilepsy or Seizures			
Mitral Valve Prolapse				Emphysema				Hemophilia			
Artificial Heart Valve				Sinus Problems				Venereal Disease			
Heart Surgery				Digestive Disorders (Acid Reflux)				Herpes			
Heart Murmur				Stomach Ulcers				Hepatitis A, B, C			
Fainting Spells				Bowel Disorder				AIDS/HIV			
Pacemaker				Artificial Joints				Cancer			
Stroke				Multiple Sclerosis				Radiation Treatment			
High Cholesterol				Muscular Dystrophy				Chemotherapy			
Diabetes				Head/neck Injuries				Auto Immune Disease			
Glaucoma				Arthritis				Alcoholism/ Drug Addiction			

Is there anything we have not mentioned that you think we should know regarding you medical history? _____

_____

WOMEN ONLY:	Are you pregnant? ☐ Yes ☐ No	Are you taking Birth Control Pills? ☐ Yes ☐ No
	Are you nursing? ☐ Yes ☐ No	Are you taking Fertility drugs? ☐ Yes ☐ No

Office Policy (please read)

1. Please help us to maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore at least 48 hours NOTICE must be given if cancellation is absolutely necessary. A fee may apply.
2. Office policy is that services are paid for each visit as they are performed. However, in certain circumstances arrangements for payment may be made by the consulting doctor.
3. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE PATIENT AND THE PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THEIR ACCOUNTS. We will prepare any necessary forms or reports to help collect your benefits from insurance companies.

Patient's Signature: _____