PRAIRIE ROOTS
DENTAL STUDIO

# Medical History

**First name:** _____ **Last name:** _____**Preferred name:** _____

**Date of birth:** _____ **Address:** _____

**City, Province:** _____ **Postal code:** _____ **Referred by:**_____

**Phone numbers:** Mobile _____ Home _____ Work _____

**Email address:** _____

**Occupation** _____ **Employer** _____

**Emergency contact name:** _____ **Phone number:** _____

**Family doctor:** _____ **Phone number:** _____

Are you currently being treated for any medical conditions, or have you been within the last year?
Yes ☐ No ☐ Please explain: _____
_____When was your last medical checkup? _____

Has there been any changes to your general health in the last year? Yes ☐ No ☐ Not Sure ☐
Please explain: _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes ☐ No ☐
If yes, please list: _____
_____

Do you have any allergies? Yes ☐ No ☐ Not Sure ☐
Medications: _____
Latex/Rubber Products: _____
Other (e.g. Hay fever, foods) _____

Have you ever had an adverse reaction to any medications or injections? Yes ☐ No ☐ Not Sure ☐
If yes, please explain: _____

Do you have, or have you ever had asthma? Yes ☐ No ☐ Not Sure ☐
If so, type of medication: _____

Do you have or have you had a replacement or repair of a heart valve, an infection of the heart, or a heart transplant? (Including infective endocarditis, congenital heart disease, etc.) Yes ☐ No ☐ Not Sure ☐
Details: _____

Have you ever had hepatitis, jaundice or liver disease? Yes ☐ No ☐ Not Sure ☐
If yes, please explain: _____

Do you have a prosthetic or artificial joint? Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Do you have, or have you had a bleeding problem or bleeding disorder? Yes ☐ No ☐ Not Sure ☐

If so, please explain: _____

Have you been hospitalized for any illness/operation(s) in the last 5 years? Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

Do you have any conditions/therapies that could affect your immune system? (Leukemia, AIDS, HIV, radiotherapy, chemotherapy, or are you on an immunosuppressant?) Yes ☐ No ☐ Not Sure ☐

If yes, please explain: _____

**Do you have any of the following? Please circle all that apply.**

| | | | |
|---|---|---|---|
| Alzheimer's | Kidney Disease | Drug/Alcohol Dependency | STDs |
| Angina/Chest Pain | Lung Disease | Steroid Therapy | Shortness of Breath |
| Anemia | Epilepsy or Seizures | Lupus | Stomach Ulcers |
| Arthritis | Fibromyalgia | Migraines | Stroke |
| Blood Transfusion | Head/Neck Injury | Hypo/Hyperglycemia | Thrush |
| Cancer | Heart Attack | Osteoporosis Medication | Thyroid Disorder |
| TMJ Disorder | Cold Sores | High/Low Blood Pressure | Parkinson's Disease |
| Tuberculosis | Hodgkin's Disease | Rheumatic Fever | Diabetes |

Are there any other conditions or diseases not listed above that you have or have had?

_____

Are there any diseases or medical problems that run in your family? (E.g. diabetes, cancer, heart disease)

Yes ☐ No ☐ Not Sure ☐ Please explain: _____

Do you smoke or use chew tobacco products? Yes ☐ No ☐

Are you Pregnant? Yes ☐ No ☐ Not Sure ☐

***The information I have given above is true to the best of my knowledge.***

Patient signature _____ Date _____

## Insurance Information

**Primary Insurance Provider:**

Name of insurance company or government program: _____

Name of policy holder: _____Date of birth: _____

Relationship to policy holder: Self ☐ Spouse ☐ Dependent ☐ Other ☐

Group/Plan #: _____ Certificate/ID #: _____

Treaty number/Health card number (if government insurance): _____

Annual deductible: $_____ Annual maximum: $_____ Basic: %_____ Major: %_____

**Secondary Insurance Provider:**

Name of insurance company or government program: _____

Name of policy holder: _____Date of birth: _____

Relationship to policy holder: Self ☐ Spouse ☐ Dependent ☐ Other ☐

Group/Plan #: _____ Certificate/ID #: _____

Treaty number/Health card number (if government insurance): _____

Annual deductible: $_____ Annual maximum: $_____ Basic: %_____ Major: %_____

☐ I would like to pay at the time of my treatment and have my insurance company reimburse me directly (non-assignment).
☐ I would like the insurance company to pay the dentist directly (assignment). I understand that I am responsible for any and all amounts not covered by my insurance plan, no matter the reason.

## Dental History

Name of previous dentist/office: _____Phone number:_____

Date of last dental visit: _____ Reason for visit: _____

Reason for changing dentists: _____

Is this office visit for emergency dental care? Yes: ☐ No: ☐

If yes, please explain: _____

Do you have pain or discomfort in your mouth? Yes: ☐ No: ☐

Do you have pain when eating? Yes: ☐ No: ☐

Do you have pain during the day? Yes: ☐ No: ☐

Do you have pain that wakes you up in the night? Yes: ☐ No: ☐

Do you have sensitivity to hot and cold? Yes: ☐ No: ☐

Have you ever had an adverse reaction to local anesthetic? Yes: ☐ No: ☐

If yes, please explain: _____

Have you ever had any serious trouble associated with any dental treatment? Yes: ☐ No: ☐

If yes, please explain: _____

How long since your last dental x-rays? Weeks ☐ Months ☐ Years ☐

Does dental treatment make you nervous? ☐ Not at all ☐ Slightly ☐ Moderately ☐ Extremely

Are you currently under active dental treatment? Yes: ☐ No: ☐

If so, description of treatment):_____

Have you ever had bleeding or swollen gums? Yes: ☐ No: ☐

If so, when? _____

Have you ever experienced dry mouth? Yes: ☐ No: ☐

If so, when? _____ For how long? _____

Have you ever been told that you have gum disease? Yes: ☐ No: ☐

If so, what treatment was done? _____

How often do you usually get your teeth professionally cleaned? _____

When was your last cleaning? _____

Have you ever had any of the following? (check all that apply)

☐ Tooth extractions ☐ Dental/Oral Surgery ☐ Root Canal Therapy

☐ Removable partial denture ☐ Fixed bridge ☐ Complete denture

☐ Filling(s) ☐ Crown ☐ Inlay/Onlay

☐ Dental Implant ☐ Orthodontic Treatment (braces, Invisalign)

With respect to your jaw joints, do you have any of the following?

☐ Clicking, popping or grinding noises ☐ Pain on opening ☐ Locking

Do you have any concerns with your mouth? _____

Are you happy with the appearance of your smile? Yes ☐ No ☐

***The information I have given above is true to the best of my knowledge.***

Signature: _____ Date: _____

# Consent for Service

I consent to the performing of dental and oral surgery procedures including the use of local anesthetic and other medications as indicated.

I accept that all emergency dental service, or any dental services performed without previous financial arrangements, must be paid for all the time the services are performed.

I understand that I am to pay my estimated patient portion at the time of my treatment and that I am financially responsible for any and all further charges not paid for by my dental insurance. As a professional courtesy this office will prepare patient insurance forms, make collections from insurance companies and will credit any such collections to the patient's account. However, if the insurance information provided to us is incorrect this office cannot be responsible for outstanding balances. Any outstanding balances are the sole responsibility of the patient.

I understand that any fee estimated provided for dental care can only be extended for a period of three months from the date of the patient examination.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I understand that the information gathered on this form and in subsequent visits may be used to contact me at my home or work to discuss matters related to this form, discuss treatment needs or outcomes, and correspond with other health care providers who may participate in my treatment. Digital photos and x-rays may be used for educational purposes or presentations while guaranteeing my anonymity. My personal information will not be given to anyone for any other purpose unless required by law.

Signature: _____ Date: _____

**We understand that unforeseen circumstances arise, but individuals who show a repeated disregard for our time and the time of our other patients by showing up late, cancelling without 24 hour notice or failing to show up for their appointment may be advised to seek dental care elsewhere.**