Allison Hill Dental Clinic

Health History

Contact Information:

Full Name: _____ Date of Birth: _____

Email: _____ Phone:(C) _____ (W/H) _____

Address: _____

Province: _____ Post Code: _____ Contact person name and phone number: _____

Do you have insurance, Yes or No? (please circle one). If yes, work or private insurance (please circle one)

Name of the company: _____

Policy #:_____ ID #: _____

Plan holder's name: _____ DOB_____

Your relationship to the plan holder: Self, spouse, dependent, other (please circle one)

Medical History

Are you currently being treated by a medical doctor/specialist? If yes, please specify:

_____

Have you ever been hospitalized/had surgery? If yes, please specify year and reason:

_____

_____

Are you currently taking any prescription drugs? If yes, please list:

_____

_____

Do you take any herbal medicines or vitamins? If yes, please list:

_____

Do you have a heart condition? For example, heart attack, angina, heart murmur, congestive heart failure, chest pain? If yes, please specify:

_____

Have you ever had/are currently having treatment for cancer? If yes, please specify year, type and treatment:_____

_____

please turn over

Are you allergic or sensitive to any medications, latex, or other? If yes, please specify:

_____

Have you ever taken corticosteroids? If yes, please specify: _____

Do you have an autoimmune disease (e.g., MS, Parkinson's, Crohn's, RA, lupus)? If yes, please specify:

_____

General Health

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

Kidney disease	High blood pressure	Liver disease	Thyroid
Lung issues (e.g., difficulty breathing/asthma, COPD)		Epilepsy	Arthritis
Lethargy	Hepatitis (A, B or C)	HIV	Diabetes
Swollen ankles	Blood disorders (e.g., abnormal bleeding/blood transfusions/anemia)		

Please share any relevant information related to the above circled, or, if there is anything else that we should know about your current health status:_____

_____

Are you pregnant? If yes, how many weeks? _____

Do you smoke? If yes, please circle all that apply: Cigarettes, cannabis, vaping per day: _____

Dental History

Have you been under regular dental care? If yes, which dentist? _____

When was your last visit and what was the treatment? _____

Have you ever had freezing? If yes, were there any complication? _____

Have you ever had any teeth extracted? If yes, were there any complications after? _____

Do any of your teeth ache? _____ Do your gums bleed when you brush/floss? _____

How many times a day do you brush? _____ How many times a day do you floss? _____

Do you knowingly grind your teeth? _____ Do you wear dentures? If yes, circle all that apply: Upper, lower, partial plate. How long have you worn dentures? _____

In your own words, why are you here today? _____

Consent to treatment

This is to certify that the above disclosed medical and dental information is correct. I consent to the dental and oral surgery procedures explained to me which are necessary or advisable for my treatment. I will assume the responsibility for the fees associated with the given procedures.

Signature: _____ Date: _____