Minor ☐ Adult ☐ Dependent Adult ☐ **MEDICAL HISTORY**

ALLERGIES	**ALERT**	**Referring DR.** **Ph.**
ASA 1 2 3 4 E FOR OFFICE USE ONLY	BMI	Pharmacy Ph.

FOR PATIENTS TO COMPLETE

BIRTH DATE DD/MO/YYYY AGE YRS M ☐ F ☐

Height _____ft ____in / _____ cm

Weight _____ lbs / _____ kg

PATIENT'S SURNAME_____ GIVEN NAME _____

Residence Address _____ City _____ Prov _____ Postal Code _____

Primary Phone (_____)_____ Alternate Phone (_____)_____ Email _____

Healthcare No. _____ Prov _____ If Minor, Parent's or Guardian's Name _____

Person Responsible for the Account _____ Address _____
FIRST NAME LAST NAME

DENTAL INSURANCE	FIRST POLICY	SECOND POLICY
Policy Holder's Name	FIRST NAME LAST NAME	FIRST NAME LAST NAME
Policy Holder's Date of Birth	dd/mo/yyyy	dd/mo/yyyy
Insurance Company		
Employer		
Group Plan / Policy No.		
Division / Section No.		
Policy Holder's Certificate No.		

Do you have a history of: **CONFIDENTIAL MEDICAL HISTORY**

	Yes	No		Yes	No		Yes	No
Heart attack			Bleeding or coagulation disorders			Asthma		
Heart congestion or failure			Blood Transfusion			COPD / Emphysema		
Heart surgery			Anemia, Sickle Cell Disease			Obstructive sleep apnea		
Angina pectoris			Hemophilia			Liver disease, hepatitis		
Congenital heart disease			Kidney problems			Alcohol - more than one drink/day		
Artificial heart valve			Urinary problems			Use of recreational drugs		
High blood pressure			Stomach ulcers			Use of medical marijuana		
Fainting or dizziness			Acid reflux, heartburn			Cold sores		
Stroke			Diabetes			HIV / AIDS		
Epilepsy or seizures			Thyroid disease			Psychiatric care		
Artificial joint replacement			Cortisone / steroid use			Radiation treatment		
Arthritis or osteoporosis			Glaucoma			Chemotherapy		

Reason for referral to our office: _____

How long has this been a problem? _____

Name of family physician _____ Phone # _____

Please provide details to all the following "yes" questions	**Yes**	**No**	**Notes**
Have you been under the care of a physician in the past 5 years?			
Have you had any past hospitalizations or operations?			
Are you on any medication or have you been on medication in the past 5 years? **PLEASE LIST**			
Do you have any allergies to any medications? (rash, swelling, difficulty breathing or hives)			
Do you have a personal or family history of difficulties or unfavourable reaction to local or general anesthetics?			
Do you have a personal or family history of malignant hyperthermia, cholinesterase deficiency or porphyria?			
Do you have any neuromuscular problems, nervous system disorders, multiple sclerosis or muscular dystrophy?			
Do you have a problem with bleeding, easy bruising or clotting?			

Continued History: Please provide details to all the following 'yes' questions	Yes	No	NOTES
Have you had any heart problems in the past?			
When you walk up stairs or walk several blocks do you get short of breath, chest pain or excessively tired?			
Do you smoke, vape, or chew tobacco? If so how much and for how many years? If you quit, when did you quit?			
Do you have a history of asthma, bronchitis, COPD or emphysema? If so have you been hospitalized for this?			
Have you ever had rheumatic or scarlet fever? If so do you have a heart murmur?			
For women: Are you or could you be pregnant?			
Are you on any special diet? Is it on the advice of a physician? Any changes in weight over the past year?			
Do you have any jaw joint (temporomandibular joint) problems or other jaw or jaw muscle problems?			
Is there anything special about your medical history or physical condition that you feel we should know?			

Date:	Signature of Patient / Parent or Guardian	Relationship to Patient if Person Completing the Form is Not the Patient

FOR OFFICE USE ONLY **CLINICAL EXAMINATION**

Date of Examination	General Health and Appearance	ASA 1 2 3 4 5 E	Resp	BP	Pulse	Temp

N	A	HEAD and NECK	N	A	ORAL	N	A	TMJ
		Lymph Nodes			Oral Mucosa			Right TMJ
		Parotid Glands			Tongue			Left TMJ
		Submandibular Glands			Floor of Mouth			Musculature
		Salivary Ducts			Pharynx			Facial Profile
		Nasal Fossa			Palate			Occlusion: Class I II III
		Skin			Dentition			Opening _____ mm
		Trachea			Periodontal Condition			Rt. Lat. _____ mm
		Thyroid			Other			Lt. Lat. _____ mm Prot. _____ mm

Radiographic Findings:

Comments and other Findings:

	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28		55	54	53	52	51	61	62	63	64	65	
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38		85	84	83	82	81	71	72	73	74	75	

Impressions and diagnosis:

Treatment plan: L. A. ☐ I.V. ☐ G.A. ☐

Treatment options discussed:

Signature of Practitioner _____

Complications Discussed:

- ☐ Swelling
- ☐ Bruising
- ☐ Bleeding
- ☐ Pain and discomfort
- ☐ Infection and dry socket
- ☐ Neurosensory impairment (temp or perm)
- ☐ Recovery time of _____days
- ☐ Injury to or loss of adjacent teeth
- ☐ Injury to adjacent restorations
- ☐ Oro-antral opening and sinusitis
- ☐ Leaving portion of roots
- ☐ Mandibular or maxillary fracture
- ☐ Decreased jaw opening
- ☐ TMJ and MPD problems
- ☐ Recession & sensitivity of adjacent teeth
- ☐ Osteonecrosis / Osteoradionecrosis
- ☐ Failure of exposed teeth to properly erupt
- ☐ Other _____