Date: ____________________

Mr/Mrs/Ms/Dr					
M ☐ F ☐		Birthdate			
Address					
City		Postal Code			
Home Phone		Cell Phone			
Occupation		Work Phone			
Primary Insurance Holder				Birthdate	
Employer					
Ins Provider		Group #		Cert #	
Secondary Insurance Holder				Birthdate	
Employer					
Ins Provider		Group #		Cert #	
Emergency Contact		Phone			
Person Responsible for Account		Phone			
Family Dentist		Family Physician			
Address		Address			
Phone		Phone			

STATEMENT OF RELEASE

I consent to have photographs, radiographs, impressions, television or audio tape records made of as requires to obtain information for diagnosis, treatment, teaching, scientific documentation and/or follow-up procedures. Further, I realized that I may or may not be informed prior to, or during the use of, the diagnostic and teaching aids.

Patient Name (please print) ____

Signed ______________________________________ Date ____________________

MEDICAL HISTORY QUESTIONNAIRE

Medical Alert (This Box for Office Use)

KITCHENER WATERLOO PROSTHODONTICS
aesthetic, implant, & reconstructive dentistry

The follow information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand.

1. Are you currently being treated for any medical condition(s) or have you been treated within the past year?

   Yes ☐ No ☐ Maybe ☐ If yes, please explain ____________________

   ____

2. When was your last medical check-up? ____________________
3. Has there been any change in your general health in the past year? Yes ☐ No☐

   If yes, please explain ____________________

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes ☐ No ☐

   If yes, please list____________________

   ____

5. Do you have any allergies? If yes, please list them using the categories below
   a. Medications ____________________
   b. Latex/rubber, metals, chemicals ____________________
   c. Other (e.g. hay fever, seasonal/ environmental, foods) ____________________
   d. Have you been tested for these allergies by a medical professional? Yes ☐ No ☐

      If yes, date and medical professional who completed the test? ____________________

6. Have you ever had a peculiar or adverse reaction to any medications or injections?

   Yes ☐ No ☐ Maybe ☐ If yes, please explain ____________________

7. Do you have or have you ever had asthma? Yes ☐ No ☐
8. Do you have or have you ever had heart or blood pressure problems? Yes ☐ No ☐
9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (e.g. infective endocarditis), heart condition from birth (e.g. congenital heart disease) or a heart transplant?

   Yes ☐ No ☐ Maybe ☐ If yes, please explain ____________________

10. Do you have a prosthetic or artificial joint? Yes ☐ No ☐

11. Has any MD recommend you take antibiotics before dental treatment? Yes ☐ No ☐
    a. If yes, which condition is it for? ____________________
12. Do you have any conditions or therapies that could affect your immune system? (e.g. leukemia, AIDS, HIV infection, radiotherapy or chemotherapy) Yes ☐ No ☐
13. Have you ever had hepatitis, jaundice or liver disease? Yes ☐ No ☐
14. Do you have a bleeding problem or disorder? Yes ☐ No ☐
15. Have you ever been hospitalized for any illness or operations? Yes ☐ No ☐

    If yes, please explain ____________________
16. Do you have or have you ever had any of the following:

☐	Chest Pain	☐	Rheumatic Fever	☐	Pacemaker	☐	Seizure	☐	Steroid Therapy
☐	Heart Attack	☐	Mitral Valve Prolapse	☐	Lung Disease	☐	Diabetes	☐	Shortness of Breath
☐	Stroke	☐	Tuberculosis	☐	Stomach Ulcers	☐	Cancer	☐	Osteoporosis
☐	Heart Murmur	☐	Thyroid Disease	☐	Kidney Disease	☐	Arthritis	☐	Drug/Alcohol Dependency

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

    Yes ☐ No ☐ If yes, please explain ____________________
18. Are there any diseases or medical conditions that run in your family? (e.g. diabetes, cancer or heart disease) Yes ☐ No ☐ If yes, please explain ____________________
19. Do you smoke or chew tobacco/vape/cannabis products? Yes ☐ No ☐
20. Are you nervous during dental treatment? Yes ☐ No ☐
21. Are you pregnant or breast feeding?

    Yes ☐ No ☐ Maybe ☐ If yes, expected due date ____________________
22. Do you identify as a patient with a disability?

    Yes ☐ No ☐ Maybe ☐ If yes, please explain ____________________

To the best of my knowledge, the above information is correct.

Signature ____________________ Date ____________________

Dentist Signature ____________________ Date ____________________