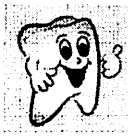
Blood Pressure _____
FOR DENTIST USE ONLY



New Castle Smile Centre

Live Love Laugh Smile

ASA
Classification_____
FOR DENTIST USE ONLY

Medical History Questionnaire

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Other: (___)_____

E-mail: _____

Emergency Contact: _____
Name Relationship Phone

Family Doctor: _____
Name Location Phone Date of last exam

1: Are you currently being treated for any medical conditions or have you been treated in the last 9 months? Y N

Please Explain? _____

2: Are you taking any medications or non-prescription drugs? Y N

Please List: _____

3: Do you have any known allergies? Eg. Medications (Penicillin, Codeines, latex) Y N

Please Specify _____

4: Have you ever had an adverse reaction to any medications or injections? Y N

Please Explain _____

5: Have you ever been advised by your doctor to take antibiotics before dental treatment? Y N

6: Do you have or have you ever had any of the following (Please circle Appropriate condition)

Hepatitis, Jaundice, Liver disease	Y	N	Bleeding problem, bleeding disorder	Y	N
Prosthetic, or artificial joint or valve	Y	N	Congenital heart disease, prosthetic cardiac valve	Y	N
Infective endocarditis, cardiac transplant	Y	N	High/low blood pressure, stroke	Y	N
Chest pain, angina or heart attack	Y	N	Immune system: leukemia, AIDS HIV infection	Y	N
Asthma, shortness of breath, lung disease	Y	N	Pacemaker	Y	N
Seizures/Epilepsy	Y	N	Arthritis	Y	N
Stomach Ulcer	Y	N	Diabetes (Type 1 or 2)	Y	N
Cancer (Type, when) _____	Y	N	Kidney Disease	Y	N
Thyroid Disease	Y	N	Steroid Therapy	Y	N
Tuberculosis	Y	N	Drug or alcohol disease	Y	N

7: Do you currently use tobacco Products _____ Y N

8: For woman only: Are you pregnant, trying to get pregnant or breastfeeding? _____ Y N

Notes: _____

_____

Newcastle Smile Centre 361 King Ave E. Newcastle On, L1B1H4 905-446-5500 info@newcastlesmilecentre.com

General Release

I the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. Should there be any changes in my health status in the future, I will advise the dental office. I authorize the dentist to preform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependants is mine and I assume the responsibility for fees associated with these services.

Patient/Guardian Signature _____ Print Name _____ Date _____

Reviewed by _____ Date _____ Reviewed By _____ Date _____

Spousal Approval

I hereby authorize the release of my treatment information to my spouse

_____

Signature of patient

Consent to SMS Messaging, text and e-mail

I hereby authorize the dental office to text or e-mail regarding my upcoming appointments and or treatment.

_____

Signature of patient

ESA Approval

I hereby authorize the release of information contained in claims to be submitted electronically to my insuring company plans administrator.

_____

Signature of patient/parent/guardian

Client# _____ Date _____

Checked by _____

Privacy Approval

I hereby certify that I have been notified of the privacy policies of this office, who to contact regarding concerns and to request further information.

_____

Signature of patient/parent/guardian

Client# _____ Date _____

Checked by _____

Newcastle Smile Centre Cancellation/ Missed appointment Policy

Your appointment time is reserved exclusively for you. We do ask for a minimum of 2 business days notice should you need to reschedule in order to avoid any missed appointment fees.