Varsity Dental Group

Therapeutic Alert

Welcome to our office. Your answers are important. Complete information will help us diagnose conditions completely, so that we may provide the safest treatment and most personal attention. **All information is confidential.**

Name: Mr. Ms. Mrs. Miss Dr. _____

Address _____

_____ Telephone Number _____
City Postal Code

Email Address _____ Cell Number _____

Date of Birth _____/_____/_____/ Hospitalization Number _____
dd mm yy

Parent/Guardian (if child) _____ Marital Status _____

Place of Work _____ Occupation _____ Work Telephone _____

How will you be paying for todays treatment? (Please Circle) Cash Cheque VISA Mastercard

Do you have dental insurance? Yes ☐ No ☐ Insurance Name _____

If applicable, Treaty Number _____ Band Name _____ DIAN _____

In case of emergency, notify Name _____

Relationship _____ Telephone _____

Who may we thank for referring you to our office? _____

** Please complete and sign the medical and dental histories on back of page. **

Office Use Only

Medical History Update: _____

Medical History

1. Name of your Physician _____
   Date of last physical exam _____ Results _____
2. Do you have a heart or circulatory problem of any kind? . . . . . Yes ☐ No ☐
3. Have you had rheumatic fever? . . . . . Yes ☐ No ☐
4. Do you have a heart murmur? . . . . . Yes ☐ No ☐
5. Are you taking any medication or pills? . . . . . Yes ☐ No ☐
   Please Specify _____
   Any other medication within the last year? . . . . . Yes ☐ No ☐
   Please Specify _____
6. Have you ever experienced an unusual reaction to any of the following: (Please Circle)
   Aspirin Penicillin Tylenol Codeine Local Anesthetics Ibuprofen Others
7. Do you have any allergies? . . . . . Yes ☐ No ☐
   Please Specify _____
8. Do you have a bleeding problem? . . . . . Yes ☐ No ☐
9. Have you ever had any injury, surgery or radiation therapy to your head, face or jaws? . . . . . Yes ☐ No ☐
10. Have you ever had any major surgery? . . . . . Yes ☐ No ☐
    Please Specify _____
11. Do you smoke or use smokeless (chewing) tobacco? . . . . . Yes ☐ No ☐
    Have you ever smoked or used smokeless (chewing) tobacco? . . . . . Yes ☐ No ☐
12. Are you Pregnant? (women) . . . . . Yes ☐ No ☐
13. Do you or have you ever had? (Please Circle)

AIDS/ARC/HIV+	Diabetes	Mental/Nervous Disorder
Anemia	Epilepsy	Sinus Trouble
Arthritis/Osteoporosis	Hay Fever	Stomach Ulcer
Asthma	Hepatitis	Stroke
Blood Disorder	High Blood Pressure	Thyroid Problems
Blood Transfusion	Liver Disease	Tuberculosis
Cancer	Lung Disease	Venereal Disease

Please specify any other illness not included in the above list: _____

Dental History

1. How long since your last dental check up? _____
2. Are you having any discomfort at this time? . . . . . Yes ☐ No ☐
3. Have you had: orthodontic treatment? . . . . . Yes ☐ No ☐
   periodontal (gum) treatment? . . . . . Yes ☐ No ☐
   wisdom teeth extracted? . . . . . Yes ☐ No ☐
   root canals? . . . . . Yes ☐ No ☐
   dental implants? . . . . . Yes ☐ No ☐
4. Do your gums bleed? . . . . . Yes ☐ No ☐
5. Do you have problems chewing? . . . . . Yes ☐ No ☐
6. Are any of your teeth sensitive or loose? . . . . . Yes ☐ No ☐
7. Do you clench or grind your teeth? . . . . . Yes ☐ No ☐
8. Do you have any pain or hear any noises in your jaw joints? . . . . . Yes ☐ No ☐
9. Does your jaw ever lock open or closed? . . . . . Yes ☐ No ☐
10. Do you have any trouble with local anesthetic (freezing)? . . . . . Yes ☐ No ☐

Patient Certification and Consent

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable including the use of local anesthetic as indicated. I will assume responsibility for fees associated with these procedures.

Patient or Parent/Guardian Signature _____ Date _____