

MONTEREY DENTAL

PLEASE PRINT CLEARLY!!

Name: _____

Date of Birth: _____ / _____ / _____ Gender: Male / Female
Last First Middle Initial
Day Mos Year

Address: _____ City & Province _____

Postal Code: _____ Email address: _____

Home Phone: _____ Work Phone: _____ Ext _____ Cell Phone: _____

Name of employer: _____ Occupation: _____

Name and phone number of emergency contact: _____

For minor children who is responsible for account? _____

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

MEDICAL HISTORY

Please check all that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV OR AIDS | <input type="checkbox"/> GLAUCOMA | |
| <input type="checkbox"/> ALCOHOL OR DRUG ABUSE | <input type="checkbox"/> GROWTHS OR TUMORS | |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> RADIATION TREATMENT |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEAD INJURIES | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ARTIFICIAL VALVES/JOINTS/PINS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ASTHMA (INHALER: Y / N) | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> BLOOD DISORDER | <input type="checkbox"/> HEPATITIS (TYPE _____) | <input type="checkbox"/> SMOKER |
| <input type="checkbox"/> BREASTFEEDING CURRENTLY | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> STD/VENEREAL DISEASE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> JAUNDICE | <input type="checkbox"/> STOMACH PROBLEMS |
| <input type="checkbox"/> CONGESTIVE HEART FAILURE | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> STROKE (WHEN _____) |
| <input type="checkbox"/> DIABETES (INSULIN: Y / N) | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TMJ PROBLEMS |
| <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> MENTAL OR NERVOUS DISORDERS | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> EXCESSIVE BLEEDING | <input type="checkbox"/> PACEMAKER | |

Women only:

Are you pregnant or planning a pregnancy? _____ Expected date of delivery: _____

ALLERGIES to:

- ASPIRIN CODEINE ERYTHROMYCIN LATEX LOCAL ANESTHETIC (FREEZING)
 PENICILLIN SULPHA OTHER (PLEASE LIST) _____

Name of Family Doctor: _____ Phone: _____

Have you been under the care of a physician recently? _____

Do you require **PREMEDICATION** for dental treatment? Yes / No

List all medications, pills, vitamins or herbs you are presently taking:
(Prescription and over the counter please)

DENTAL HISTORY

Date of last dental visit: _____ What was done at that time? _____

Have you ever fainted or had complications following dental treatment? Explain: _____

Have you ever had any injury, surgery or x-ray therapy to the face or jaws? _____

***Consent: To the best of my knowledge all of the preceding answers and information provided are true, complete and accurate. If I ever have changes (health, medications, address, insurance, etc) I will inform the dental office at my next appointment. I grant permission to you and your assignees to telephone me to discuss matters related to this form. I assume responsibility for all fees associated to my dental treatment.**

Date: _____ Signature of Patient, Parent/Guardian: _____