CONFIDENTIAL MEDICAL HISTORY

Name _____ ☐ Male ☐ Female Res. Phone _____
Last Name, First Name

Address _____ Bus. Phone _____

City _____ Postal Code _____

Date of Birth _____ Cell Phone: _____
Day Month Year

Employer _____ Email: _____

Name of husband/wife or father/mother or guardian, where applicable _____

Phone _____ Employer _____

Referring Dentist _____ Family Physician _____

Do you have Dental Insurance coverage? _____ (If yes, see page 2)

Have you been hospitalized or had a serious illness in the last 2 years? _____

What drugs and medication including Aspirin are you taking at this time? _____

_____

What drugs have you **stopped** taking in the last six months? _____

Has your Physician recommended you take antibiotics prior to dental treatment? NO YES

Do you have or have you ever had:

High Blood Pressure _____	NO	YES
Cancer _____	NO	YES
Diabetes _____	NO	YES
Hepatitis _____	NO	YES
H.I.V. (AIDS) _____	NO	YES
Abnormal Heart Condition _____	NO	YES
History of Coronary _____	NO	YES
Rheumatic Fever _____	NO	YES
Heart Murmur _____	NO	YES
Joint Replacement (i.e. Hip) _____	NO	YES
Abnormal bleeding from cuts, extractions, etc. _____	NO	YES
Epilepsy _____	NO	YES
Allergies (inc. Drug Allergies) _____	NO	YES
_____		
Special Diet _____	NO	YES
Do you smoke: _____	NO	YES
If so, how much? _____		
Are you pregnant? _____	NO	YES
If so, what month are you in? _____		
Do you take birth control pills? _____	NO	YES

DENTAL HISTORY

Are your teeth sensitive to: Heat _____	NO	YES
Cold _____	NO	YES
Sweets _____	NO	YES
Biting pressure ___	NO	YES
Do you clench or grind your teeth? _____	NO	YES
Do any teeth feel loose? _____	NO	YES
Do your gums bleed when brushing? _____	NO	YES
Have your gums ever been treated? _____	NO	YES
Have you experienced any problems with local anaesthetic? _____	NO	YES

How often do you have your teeth cleaned by your dentist?

_____

Is there anything we have not mentioned, that you think we should know regarding your medical history?

Notes: _____

_____

_____

_____

_____

I, _____ hereby consent to have Dr. Glick release and/or discuss my medical history, dental history, periodontal status, periodontal treatment, radiographs and clinical records with my consulting and treating dentists and physicians. I further authorize the release of any requested information to my insurance carrier, including electronic submissions. This will help determine their liability with respect to dental benefits.

Signed _____ Dated _____