Westhills DENTAL

First Name _____ **Last Name** _____

Birthdate _____ **Email Address** _____

Address _____ **Postal Code** _____

Cell Phone _____ **Employer** _____ **Care Card#**_____

Emergency Contact Name _____ **Emergency Contact #** _____

1. Are you being treated for any medical conditions at the present time or have been treated within the last year?
If yes, please describe _____

2. When was your last medical checkup? _____

3. Has there been any change in your general health over the last year? Y/N _____
If yes, please describe _____

4. Are you taking any medications, non- prescription drugs, recreational drugs or herbal supplements of any kind?
_____
_____
_____
_____

5. Do you have any allergies? Y/N _____ If yes, please list in the following categories below:
Medications _____
Latex/ Rubber Products _____
Other (ie- Hayfever, Foods) _____

6. Have you ever had any uncommon or adverse reactions to any medication or injections? Y/N _____
If yes, please describe _____

7. Do you, or have you ever had asthma? Y/N _____ If yes, do you use a puffer? Which? _____

8. Do you or have you ever had blood pressure problems? Y/N _____

9. Do you or have you ever had a replacement or repair of a heart valve, an infection of the heart (ie: infective endocarditis), a heart condition from birth (ie: congenital heart disease) or heart transplant? Y/N ___

10. Are you taking or have you taken any osteoporosis medications? (ie: Fosamax, Acetone) Y/N _____
If yes, please note which _____

11. Have you ever had hepatitis, jaundice or liver disease? Y/N _____ If yes, which type of hepatitis? _____

12. Do you have diabetes Y/N _____ Type 1 _____ Type 2 _____
How is your diabetes being controlled? ie: Diet, Medication _____

13. Are you undergoing any therapies that can affect your immune system? ie: radiotherapy, chemotherapy?
_____

14. Do you have or have you ever had any of the following?

__Arthritis/ Rheumatism
__Asthma
__Cancer
__Chest Pain, Angina
__Crohn's
__Drug/ Alcohol Dependency
__Fainting or dizzy spells
__Glaucoma
__Head/Neck Injury
__Heart Attack
__Heart Murmur
__Hepatitis A
__Hepatitis B
__Hepatitis C
__Hyperglycemia
__Jaundice
__Kidney Disease
__Liver Disease
__Lung Disease/Emphysema
__Malignant Hyperthermia
__Mitral Valve Prolapse
__Pacemaker
__Rheumatic/Scarlet Fever
__Seizures (Epilepsy)
__Shortness of breath
__Sickle Cell Disease
__Sinus Trouble
__Stomach Ulcers
__Stroke
__Thyroid Disease
__Tuberculosis
__Herpes
__Psychiatric/Mental Disorders
__**NONE OF THE ABOVE**

15. Do you or have you had any conditions or diseases not previously listed that we should be aware of? Y/N _____
If yes, please describe _____

16. Are there any diseases or medical problems that run in your family? (Diabetes, Cancer, Heart Disease)
If yes, please list all _____

17. Do you have a bleeding problem or a bleeding Disorder Y/N _____

18. Have you ever had a transplant? (Heart, Lungs, or Organs) Y/N _____

19.Do you have a prosthetic or artificial joint? Y/ N _____

20. Have you ever been hospitalized for any illness or operations? Y/N _____
If yes, please explain _____

21.Have you ever had any injury or surgery to your face or jaw? Y/N _____

22.Do you smoke or chew tobacco Products? Y/N _____

23.Are you nervous about dental treatment? Y/ N _____

24. Is there anything about your health we should be made aware of? Y/N _____

25. Do you wish to speak to the doctor privately about any problem or medical condition? Y/N _____

26. Has the child patient recently had any of the following:
Chicken Pox ___ Measels ___ Mumps ____ Strep Throat ____ Tonsilitis ____ None of the above ____

27. Are there any immunizations that the child is not up to date with? Y/N ___ Please List_____

28. For women only: Are you breastfeeding? Y/N _____

29. For women only: Are you pregnant? Y/N _____ How far along? _____ Delivery Date? _____

The information I have provided above is true to the best of my knowledge.

The Personal Health Information Act permits us to collect and use your personal health information. In certain circumstances, PHIA also allows us to share it with other healthcare providers both in, and outside our organization. We do this for purposes such as:

To provide you with healthcare;

To get payment for your care which could include private insurers;

To do health system planning and research regarding your treatment;

To report as required by law.

Unless you tell us not to, we can share your personal health information with any health care provider who has, is or will be providing you with health care. Members of your health care team are only allowed access to the information they need to give you the health care you need. If you tell us not to share your information with a health care provider, we will not share your information unless permitted or required by law to do so. Choosing not to consent to this can prolong the process of us referring you to specialists and other providers. Please tell a member of our team if you do NOT want your information shared with a health care provider.

Today's Date _____

Patient's Name (Please Print) _____ **Patient's Signature** _____

Thank you for choosing our practice!

Westhills
DENTAL