Dr. Steven A. Malo / Dr. Ian Malo

INTRODUCTORY QUESTIONNAIRE

IN order to render and optimum health services it is necessary to obtain a variety of vital personal information.

ALL INFORMATION OBTAINED IS CONFIDENTIAL.

☐ Mr.
☐ Mrs. Last Name: _____ M or F Age:_____
☐ Ms. First Name: _____ Birth date: _____
M D Y

Address/Street: _____ City:_____

Postal Code: _____ 911# _____ Phone Home# _____

Place of employment _____ Work# _____

MEDICAL HISTORY

Name of Physician: _____ Phone:_____

Medical Alert _____

Do you have or have you had any of the following? Indicate by ✓

☐ Allergies to medicine. List _____

☐ Heart problems of murmurs
☐ High blood pressure
☐ Nervous problems
☐ Radiation treatments
☐ Hepatitis
☐ Diabetes
☐ Malignancies
☐ Latex Allergies
☐ Bleeding Disorders
☐ Allergies to anaesthetics
☐ Asthma
☐ Epilepsy
☐ Rheumatic Fever
☐ Steroid / Cortisone Therapy
☐ Are you pregnant
☐ Hip, knee or joint replacement
Date of replacement _____

Have you tested **positive** for H.I.V. Virus (AIDS)? ☐ Yes ☐ No
Are you currently under **ACTIVE CARE** by your Physician? ☐ Yes ☐ No
Are you currently taking medication? ☐ Yes ☐ No
If Yes, list _____
_____

Please describe any current medical treatment, impending operations, drug therapy or any other medical information that may possibly offset your dental treatment.

_____

_____

DENTAL HISTORY

When was your last complete dental examination? _____

Who was your last dentist? _____

Do you have any sores in your mouth? _____

Have you ever had a tooth extracted? _____

If yes, where there any complications? _____

Are you under the care of a Dental Specialist? _____

☐ Yes, Name _____ Tel: _____

I authorize Dr. Steven A. Malo and the assistants that he delegates to perform any dental and oral surgical procedures including the use of radiographs (X-rays) and drugs, that he feels necessary for my oral health, and I assume the responsibility for fees associated with those procedures. Upon each visit, I will notify Dr. Malo and the assistants of any updates in my medical history or any changes in the medication I am currently taking. I authorize Dr. Steven A. Malo to contact my physician if he feels it necessary to discuss my medical history.

Please note:
Your appointment time is especially reserved for you. **As a courtesy, we require 24 HOURS notice for all cancellations at which time we will be happy to reschedule your appointment.**
If the office is not notified, changes will be billed for your appointment time.
Office policy is such that services are paid for at EACH visit as they are performed. However, in special circumstances arrangements for payment can be made by consulting with office administration.

Date: _____ Signature: _____

INSURANCE INFORMATION

Do you have Dental Insurance? ☐ Yes ☐ No
If Yes, complete the following:
Insurance Company: _____

Dental Insurance Policy Holder: _____ D.O.B. _____

Insured Place of Employment _____

Policy # _____ I.D. # _____

Do you have Secondary7 Insurance? ☐ Yes ☐ No
Secondary Insurance Company: _____

Secondary Insurance Policy Holder: _____D.O.B. _____

Secondary Insured Place of Employment: _____

Policy # _____ I.D.# _____

Are you on Ontario Works ☐ Yes
Name of Caseworker _____