MALO FAMILY DENTISTRY

Name: Date of Birth: Sex: M F

Address: City: Province: Postal:

Phone (home): (work): (cell):

Email:

Occupation: Employer:

Family Doctor: Phone

Name of Specialist(s): Phone:

Referred by: Person Responsible for Account:

Emergency Contact: Phone:

O.H.I.P. # Drivers Lic. or S.I.N. #

INSURANCE INFORMATION

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

Insurance Company:

Dental Insurance Policy Holder: Date of Birth:

Insured Place of Employment

Policy # I.D. #

Do you have Secondary Insurance? ☐ No ☐ Yes, complete the following:

Secondary Insurance Company:

Secondary Insurance Policy Holder: Date of Birth:

Secondary Insurance Place of Employment:

Policy # I.D. #

Are you on Ontario Works? ☐ No ☐ Yes, name of Caseworker:

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? ☐ Yes, any complications:

Are you under the care of a Dental Specialist? ☐ Yes, name: Phone:

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 helath, 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 dicuss my medical history.

Please Note: Your appointment time is expecially 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: ____

Please check **Y**es or **N**o for any of the following conditions as they apply to your health status

Are you ALLERGIC to or have you had a REACTION to any of the following:

	Y	N
Local anesthetics (freezing)	☐	☐
Antibiotic: *Penicillin, Amoxicillin, Clindamycin, Celphalosporins, Cipro., Metronidazole, Sulfa, Tetracycline, Other:*	☐	☐
Sedatives: *Diazepam (Valium), Midazolam (Versed), Triazolam (Halicon), Lorazepam (Ativan), Other:*	☐	☐
Pain Relievers: *ASA (Asprin), Acetaminophen (Tylenol), Ibuprofin (Advil, Motrin), Naxproxen, Toradol, Other:*	☐	☐
Narcotics: *Codeine, Oxycodone, Hydrocodone, Demerol, Morphine, Talwin, Tramadol, Other:*	☐	☐
Iodine, dyes	☐	☐
Any metal / plastic (including jewelry)	☐	☐
Other allergies	☐	☐
Allergen: *rxn type: GI* ☐ *skin* ☐ *rhinitis* ☐ *facial edema* ☐ *dyspnea* ☐ *anaphylaxis* ☐		

GENERAL

	Y	N
Have you geen treated for any medical conditions in the past year?	☐	☐
List ALL medications you are taking including over the counter medications.		
What pharmacy do you use?		

HEENT

	Y	N
Sinus Problems	☐	☐
Persistent swollend glands in neck	☐	☐
Glaucoma	☐	☐

RESPIRATORY

	Y	N
Shortness of breath	☐	☐
Respiratory disease	☐	☐
Tuberculosis	☐	☐
COPD: *Emphysema* ☐ *Chronic Bronchitis* ☐ *Bronchiectasis* ☐	☐	☐
Sleep Apnea	☐	☐
Asthma: *mild* ○ *moderate* ○ *severe* ○	☐	☐
triggers: *frequency:* *last attack:* *steroid dependent* ☐ *ER or ICU admissions* ☐		

CVS / PVS

	Y	N
Chest Pain / Angina	☐	☐
triggers: *frequency:* *last attack:* *relief with:* *Rest* ☐ *Nitrates* ☐		
Heart Attack *if yes, please give approximate date(s):* *, length of hospitalization:*	☐	☐
High blood pressure	☐	☐
Arrythmia (Fast, Slow or Irregular heart beat)	☐	☐
Enlarged heart or Congestive heart failure	☐	☐
Heart surgery *if yes, what type:* *, date:*	☐	☐
Heart murmer	☐	☐
Endocarditis	☐	☐
Heart Pacemaker or AICD (automatic implantable cardiac defibrillator)	☐	☐
HHT (hereditary hemorrhagic telangiectasia)	☐	☐
Have you ever taken appetite suppressant drugs	☐	☐
echo cardiogram ☐ *date:* *lab:* *copy obtained:* ☐		

GI / GU

	Y	N
Liver disease	☐	☐
Crohn's disease, or Ulcerative colitis	☐	☐
Stomach ulcers	☐	☐
Kidney disease	☐	☐

MUSCULOSKELETAL

	Y	N
Arthritis / joint pain	☐	☐
Joint replacement *(hip, knee, shoulder, ankle)* *if yes, when:*	☐	☐
Osteoporosis or Osteopenia	☐	☐
Have you ever taken medication for Osteoporosis or Osteopenia? *if yes, year you started:*	☐	☐
alendronate (Fosamax) ☐ *risedronate (Actonel)* ☐ *bandronate (Boniva)* ☐ *etidronate (Didrocal, Didronel)* ☐		

CNS

	Y	N
Stroke		
Fainting or dizziness		
Epilepsy / Seizure disorder		

HEMATOLOGY

	Y	N
Blood disease / disorder such as: Anemia, Hemophilia, Thrombocytopenia, Other		
Prolonged bleeding / abnormal bleeding		
Have you ever required a blook transfusion?		
Coumadinized patient ☐ *last INR value:* *date:* *target INR:*		

ENDOCRINE

	Y	N
Diabetes *if yes, type I* ☐ *type II* ☐		
Thyroid disease		
Addison's disease		
Have you ever been on steroid medications?		

IMMUNE SYSTEM

	Y	N
Splenectomy		
Organ transplantation (heart, kidney, lung, bone, etc.)		
Auto Immune Disease such as: *Lupus (SLE)* ☐ *Sjogren's syndrome* ☐ *Rheumatoid arthritis* ☐		
Implanted medical devices including shunts		

INFECTIOUS DISEASE

	Y	N
Hepatitus - Type: A, B or C		
HIV / AIDS		

MENTAL HEALTH

	Y	N
Anxiety and / or Depression		
Dementia or Alzheimer's disease		
Other mental illness		

SOCIAL

	Y	N
do you drink alcohol? *drinks per week:*		
Have you ever smoked? *Pk-years*		
Do you use recreational drugs?		

NEOPLASM

	Y	N
Have you ever had cancer? *if yes, type:*		
Surgery ☐ *Chemo* ☐ *date completed:* *Radiation* ☐ *field:* *rads:* *IV Zomete or Aredia* ☐ *date:*		

OTHER

	Y	N
Are there any other medical conditions not listed above that we should be aware of?		

WOMEN ONLY

	Y	N
Are you pregnant? if yes, how many weeks:		
Are you nursing?		

Declaration and Release

I hereby declare that, to the best of my knowledge, the information I have provided is accurate and complete. I understand that an accurate medical history is important for both safe and efficient dental care, and I release all the dentists and employees of Malo Fmaily Dentistry from any liability arising from errors or omissions in the information I have provided. In addition, I authorize communication with my physicians, pharmacists or other health care providers if, and when, my treating dentist or hygienist deems it necessary to either obtain or provide relevant information about my helath status. I will advise this office of any changes regarding my health and / or any other information which I have provided. I understand that payment for all dental services for myself and my dependants is my responsibility regardless of insurance benefits. I am aware that a written copy of the privacy policy of this office is available upon request.

Name: ______________________ Signature: ______________________

Signature of Parent or Guardian if patient is under the age of 16 or patient is adult under power of attorney ______________________

Summary Notes: ______________________