MEDICAL HISTORY FORM

Patient Name:____ **Date of Birth:**___________________________

Address:____

Address City Province Postal Code

Email Address:______________________________________

Home Phone Number:______________________ **Work:** ______________________**Cell:**__________________________

Person to Contact in case of Emergency:______________________________ **Phone Number:**___________________________

Physician's Name:____ **Physician's Phone #:**________________________

Are you now under the care of a doctor? Yes ☐ No ☐ If yes, for what reason?____

Are you pregnant? ☐ No ☐ Yes **Could you be pregnant?** ☐ No ☐ Yes **Are you nursing?** ☐ No ☐ Yes

Are you presently taking any medications? Yes ☐ No ☐

Please list all medications being taken, including; prescriptions, over-the-counter medications, vitamins and natural products:

____

____

____

ALLERGIES/SENSITIVITIES:

Check all that apply

☐ Penicillin ☐Other Antibiotic:
☐ Local Anesthetic
☐ Metals ☐ Latex
☐Aspirin ☐ Codeine
☐ Other:

	YES	NO		YES	NO		YES	NO		YES	NO
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	HIV/AIDS	☐	☐	Scarlet Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Arthritis/Gout	☐	☐	Epilepsy/Seizures	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Asthma	☐	☐	Fainting Spells	☐	☐	Leukemia	☐	☐	Stomach/Intestinal Disease	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Breathing Problem	☐	☐	Frequent Headaches	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Bruise Easily	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Cancer	☐	☐	Hay Fever	☐	☐	Pain in Jaw Joints	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Heart Attack	☐	☐	Parathyroid Disease	☐	☐	Tumors or Growths	☐	☐
Chest Pains	☐	☐	Heart Murmur	☐	☐	Psychiatric Care	☐	☐	Ulcers	☐	☐
Cold Sores	☐	☐	Heart Pace Maker	☐	☐	Radiation Treatments	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disorder	☐	☐	Heart Trouble	☐	☐	Recent Weight Loss	☐	☐	Yellow Jaundice	☐	☐
Convulsions	☐	☐	Hemophilia	☐	☐	Renal Dialysis	☐	☐			
Cortisone Meds	☐	☐	Hepatitis A/B/C	☐	☐	Other:					

Do you currently smoke or use any of the following tobacco products? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ Vaporizer

How much?__________________How often?__________________How long ago did you quit?____________________

Do you currently smoke or use any of the following Cannabis products? ☐ Smoked/Inhaled Cannabis ☐ Cannabis Oil ☐ Cannabis Capsules

How much (g/ml)?____________________How often?__________________ How long ago did you quit?____________________

DENTAL HISTORY

When was your last dental check-up? ___________________________ **Last Cleaning?**_______________________________

Did you have x-rays at this time?____________________________

Do you have any Implants, Crowns, a Bridge or Dentures? ☐ No ☐ Yes If yes, please explain:

Do you have any current dental concerns? ☐ No ☐ Yes If yes, please explain:

Please check if you have or if you have had problems with any of the following:

	YES	NO		YES	NO		YES	NO
Bad Breath	☐	☐	Dry Mouth	☐	☐	Orthodontic Treatment	☐	☐
Bleeding Gums	☐	☐	Fingernail Biting	☐	☐	Periodontal Treatment	☐	☐
Blisters on the Lips or Mouth	☐	☐	Food Collection Between Teeth	☐	☐	Sensitivity to Pressure	☐	☐
Broken Fillings	☐	☐	Grinding/Clenching Teeth	☐	☐	Sensitivity to Sweets	☐	☐
Burning Sensation on Tongue	☐	☐	Jaw Pain/Tenderness	☐	☐	Sensitivity to Temperature	☐	☐
Cheek/Lip Biting	☐	☐	Loose Teeth	☐	☐	Sores or Growths in Mouth	☐	☐
Clicking or Popping of Jaw	☐	☐	Mouth Breathing	☐	☐	Swollen or Tender Gums	☐	☐

Is there anything about your smile that you wish to improve? ☐ No ☐ Yes If yes, please explain:

How did you hear about us?

☐ A Friend/Family Member	☐ Google	☐ Facebook	☐ Location/Signage
☐ An Office in Our Building	☐ A Specialist's Office	☐ Staff Member	☐ Other

Patient/Guardian signature:____ Date_______________________

Dentist signature:____ Date_______________________

NEPEAN FAMILY DENTAL
460 W Hunt Club Rd, Unit 104
Ottawa, ON K2E 1B2
613-224-6332
info@nepeanfamilydental.com

I hereby authorize the Dentists at Nepean Family Dental, and whoever he/she may designate as his/her assistants and/or hygienists, to perform diagnostic, preventative and restorative procedures on me or my dependent.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include, but are not limited to:

- Sensitivity of the teeth and gums following dental cleanings and gum treatments.
- Post treatment pressure, tooth temperature sensitivity, pain or throbbing.
- Jaw joint tenderness or pain after treatment.

I further consent to the administration of any drugs that may be deemed necessary in my/my child's case, including, but not limited to:

- Local anesthetics, antibiotics and analgesics.

I understand that there is a slight element of risk inherent in the administration of any drug or anesthetic. This risk includes, but is not limited to, the following complications:

- Pain
- Discoloration of skin due to injury of blood vessels
- Injury to nerves that may be temporary or permanent
- Allergic reactions
- Cardiac arrest

A more complete explanation of all complications is available to me upon request from the Doctor.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

______________________________ Patient/Parent/Guardian Signature

______________________________ Date

WRITTEN STATEMENT OF INFORMATION PRACTICES AND NOTICE OF PURPOSES

NEPEAN FAMILY DENTAL
460 W Hunt Club Rd, Unit 104
613-224-6332
info@nepeanfamilydental.com

Our office understands the importance of protecting your personal health information. To help you understand how we are doing that, we have outlined below how our office is collecting, using and disclosing your personal health information.

This office will collect, use and disclose information about you for the following purposes:

- To assess your health needs and provide safe and efficient dental care.
- To send and receive email, voice or text message reminders or correspondence.
- To enable us to contact and maintain communication with you to distribute health care information and to book and confirm appointments.
- To communicate with other treating health care providers, including other dentists, physicians, pharmacists and lab technicians.
- For teaching and demonstrating purposes on an anonymous basis.
- To complete and submit dental claims for third party adjudication and payment.
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act.
- To deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, as necessary.
- To invoice for goods and services.
- To process credit card payments.
- To collect unpaid accounts.
- To assist this office to comply with all regulatory requirements and to comply generally with the law.

The storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols; our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Your information may be accessed by regulatory authorities under the terms of the *Regulated Health Professions Act (RHPA)* for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Please note that any questions or concerns that you might have about your personal health information can be directed to Dr. Brar. She can be reached at the above address, phone number and/or email.

By signing the consent section of this Patient Consent Form, you agree that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Our office will not, under any condition, supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for your review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

If you choose to withdraw your consent for use or disclosure of your personal information, we will explain the ramifications of that decision, and the process.

_______________________________ _______________________________

Patient/Parent/Guardian Signature Date