

# Peace Park Dental

In order to render optimum dental service, it is necessary to become acquainted with the vital information related to each patient. All information is strictly confidential and although some questions may seem unimportant at the moment, they may become vital in the case of an emergency.

## PATIENT PERSONAL INFORMATION

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Referred by: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email : \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Preferred method of contact: email \_\_\_ cell phone \_\_\_ home phone \_\_\_ Student: \_\_\_ School: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation \_\_\_\_\_ Language Preferred: \_\_\_\_\_

Health Card # \_\_\_\_\_

## MEDICAL Do you have or ever had?

<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Bacterial Endocarditis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Angina	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Stroke	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Hiv/Aids	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Lupus
<input type="checkbox"/> Drug Dependency	<input type="checkbox"/> Alcohol Dependency			

- Have you ever had a serious illness or are you currently under the care of a physician? Yes \_\_\_ No \_\_\_  
Is so, please describe \_\_\_\_\_
- Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_
- Medical Specialist Name: \_\_\_\_\_ Phone: \_\_\_\_\_ specialty \_\_\_\_\_
- Have you had major surgery? If so, please describe:  
Procedure \_\_\_\_\_ Date \_\_\_\_\_  
Procedure \_\_\_\_\_ Date \_\_\_\_\_
- List ANY medication, drugs, vitamins or pills you are presently taking:  
\_\_\_\_\_
- Name of Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you require Premedication before dental appointments? Yes \_\_\_ No \_\_\_  
If so, please describe reason \_\_\_\_\_
- Do you have? Asthma \_\_\_ Hay Fever \_\_\_ Skin Rash \_\_\_ Allergies \_\_\_
- Are you currently using? Tobacco Products \_\_\_ Street Drugs \_\_\_ Naturopathic/herbal products \_\_\_
- Have you ever experience an unusual reaction to:  
i) Anesthetic freezing \_\_\_ ii) Aspirin \_\_\_  
iii) Sulfa based medication \_\_\_ iv) Penicillin based medication \_\_\_  
iv) Sleeping Pills \_\_\_ vi) Codeine \_\_\_
- Do you bruise easily or bleed abnormally? Yes \_\_\_ No \_\_\_
- Do you have any blood disorders such as: anemia or thin blood? Yes \_\_\_ No \_\_\_
- Have you had (please circle) an injury, surgery, radiation treatment on your head, face, jaw? Yes \_\_\_ No \_\_\_
- Do you have a prosthetic or artificial joint? If so, where \_\_\_\_\_ Yes \_\_\_ No \_\_\_
- Are there any medical conditions or diseases not listed above that you have or had? Yes \_\_\_ No \_\_\_  
If so, please explain \_\_\_\_\_
- Women only, are you pregnant? Yes \_\_\_ No \_\_\_ If so, expected due date? \_\_\_\_\_

**DENTAL**

1. Do you have any dental concerns? \_\_\_\_\_
2. How frequently do you visit your dentist?    \_\_ 3-6 months    \_\_ Annually    \_\_ Other
3. Have you had teeth extracted due to:  
      \_\_ An accident            \_\_ Decay            \_\_ Gum disease            \_\_ Orthodontics
4. Do you have or had?  
      \_\_ Fixed Bridge(s)        \_\_ Implants        \_\_ Partial Denture(s)        \_\_ Full Denture(s)  
      \_\_ Orthodontics        \_\_ Veneers        \_\_ Crowns            \_\_ Root Canal Treatment  
      \_\_ Periodontal Treatment        \_\_ Oral Piercings
5. Do you have any oral habits, such as?  
      \_\_ Clenching            \_\_ Grinding        \_\_ Nail Biting            \_\_ Other
6. How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

**DENTAL INSURANCE**

Do you have dental insurance? Yes \_\_ No \_\_

**PRIMARY DENTAL PLAN**

Subscriber Name : \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Division # \_\_\_\_\_

ID/Certificate # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Employer Name: \_\_\_\_\_

**SECONDARY DENTAL PLAN**

Subscriber Name: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Group/Policy # \_\_\_\_\_ Division # \_\_\_\_\_

ID/Certificate # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Employer Name: \_\_\_\_\_

**PATIENT CERTIFICATION & APPROVAL** - I the undersigned, certify that all of the above medical & dental information is true to the best of my knowledge and I have not omitted any pertinent information.

**PATIENT CONSENT/PRIVACY CODE** - I the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for the fees associated with these procedures. I have reviewed how your office will use my personal information (patient contact, specialist referrals, office promotions...) and the steps your office is taking to protect my information, I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Dr. Nabil Malak can collect, use and disclose this personal information as set out in the information about the office's privacy policies.

Date \_\_\_\_\_ Print Name \_\_\_\_\_ Signature \_\_\_\_\_