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?

__Hepatitis	__High Blood Pressure	__ Jaundice	__ Rheumatic Fever	__Diabetes
__ Tuberculosis	__Lung Disease	__ Cancer	__ Thyroid Disease	__ Kidney Disease
__Bacterial Endocarditis	__Heart Attack	__ Heart Murmur	__ Pacemaker	__ Heart Surgery
__ Angina	__ Mitral Valve Prolapse	__Stroke	__ Joint Replacement	__ Epilepsy
__Stomach Ulcers	__ Hiv/Aids	__Sinusitis	__Arthritis	__ Lupus
__Drug Dependency	__Alcohol Dependency			

1. Have you ever had a serious illness or are you currently under the care of a physician? Yes__ No__
   Is so, please describe _____
2. Physician Name: _____Phone: _____
3. Medical Specialist Name: _____Phone: _____specialty _____
4. Have you had major surgery? If so, please describe:
   Procedure_____Date _____
   Procedure_____Date_____
5. List ANY medication, drugs, vitamins or pills you are presently taking:
   _____
6. Name of Pharmacy: _____Phone:_____
7. Do you require Premedication before dental appointments? Yes__ No __
   If so, please describe reason _____
8. Do you have? Asthma ___ Hay Fever ___ Skin Rash __ Allergies __
9. Are you currently using? Tobacco Products ___ Street Drugs ___ Naturopathic/herbal products ___
10. 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 ___
11. Do you bruise easily or bleed abnormally? Yes __ No __
12. Do you have any blood disorders such as: anemia or thin blood? Yes__ No __
13. Have you had (please circle) an injury, surgery, radiation treatment on your head, face, jaw? Yes __ No __
14. Do you have a prosthetic or artificial joint? If so, where _____ Yes __ No __
15. Are there any medical conditions or diseases not listed above that you have or had? Yes __ No __
    If so, please explain _____
16. 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 _____