

**Toothpicks Medical/Dental History**

**NAME:** Mr/Master/Mrs/Ms/Miss/Dr (circle one)

\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

BUSINESS PHONE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

HOW DID YOU HEAR OF OUR SERVICES?

\_\_\_\_\_

**The power of attorney or in case of an emergency or we should notify:**

**NAME:** \_\_\_\_\_

**RELATIONSHIP:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_

PHONE: \_\_\_\_\_

PHARMACY: \_\_\_\_\_

PHONE: \_\_\_\_\_

DENTIST \_\_\_\_\_

DATE OF LAST DENTAL APPOINTMENT?

\_\_\_\_\_

REASON AND TREATMENT PERFORMED:

\_\_\_\_\_

THE FOLLOWING IS REQUIRED INFORMATION THAT ENABLES US TO PROVIDE YOU WITH  
THE BEST POSSIBLE CARE

1. Are you currently being treated for any medical condition or have you received treatment in the past 2 years? If yes, please explain.

\_\_\_\_\_

2. When was your last complete physical exam? Please report any findings.

\_\_\_\_\_

3. Have you ever had any type of surgery? When? What kind?

\_\_\_\_\_

4. Have you ever been hospitalized? When and what for?

\_\_\_\_\_

5. Has there been any change in your general health within the past year? Please explain.

\_\_\_\_\_

6. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Please list.

\_\_\_\_\_

7. Do you have any allergies? Please list all allergies, they are all important for us to be aware of.

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8. Have you ever had an adverse reaction to any medications or injections? If yes, please explain.

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9. Have you ever been advised by your doctor to take antibiotics prior to having any dental work?

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10. Do you smoke or chew tobacco products? How much per day?

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11. Are you on any type of special diet? Which kind?

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12. Do you have or have you ever had any of the following? Please circle.

AIDS/HIV	Epilepsy/Seizures	Mitral Valve Prolapse or Heart Murmur
Arthritis	Heart Attack/ Disease	Pacemaker
Asthma	Herpes	Prosthetic Heart Valve
Cancer	High/Low Blood Pressure	Scarlet or Rheumatic Fever
Chemotherapy/Radiation	Hyper/Hypo Glycemia	Shortness of Breath
Chest Pain	Jaundice	Steroid/Cortisone Therapy
Cold Sores	Joint Replacement (Knee, Hip)	Stomach/Intestinal Problems
Congenital Heart Defect	Liver Disease	Stomach Ulcers
Diabetes	Lung Disease	Stroke
Drug/Alcohol Addiction	Kidney Disease	Thyroid Disease
Eating Disorders	Malignant Hyperthermia	Tuberculosis
	Mental/Nervous Disorder	Other _____

13. Are there any conditions/diseases not listed above that you have or have had?

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14. WOMEN ONLY: Are you pregnant? If yes, when is your due date?

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#### GENERAL RELEASE

I certify that I have read, understood and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. As may be required I consent to my physician, dentist, pharmacist or other health care provider to be contacted regarding any specific health questions. I authorize Toothpicks staff to perform necessary diagnostic procedures and treatment as required to achieve the proper level of dental care. I understand that I am financially responsible to Toothpicks for dental services provided even if my insurance coverage may not be all inclusive. I am aware that a service charge of 1.5% per month (18% per annum) will be applied to any unpaid balances. I understand that estimates provided may be subject to change as treatment needs indicate, and any difference (higher or lower) will be reflected in my statement. I also understand that Toothpicks will comply with all policies and procedures as required by the PIPEDA, and I have read this act and consent to the collection, use and disclosure of my personal information.

I have read the above conditions of treatment and payment and agree to their content. I also authorize Toothpicks to release any records as required to my dentist or a referred dentist or specialist.

Signature of Patient, Guardian, or Parent \_\_\_\_\_ Date: \_\_\_\_\_