CONFIDENTIAL MEDICAL HISTORY

MEDICAL ALERT: _____

Name: Mr./Miss/Mrs./Ms./Dr.

_____

Date of Birth: _____

Address (Home): _____

_____

_____

Phone: _____

Email: _____

Who referred you to our company:

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

_____

Relationship: _____

Day-time phone: _____

Night: _____ Cell: _____

Email: _____

Secondary Contact Person: _____

Relationship: _____

Phone Numbers: _____

Name of Family Doctor: _____

Phone # and Address: _____

_____

Names/Phone numbers of Medical Specialists:

Name	Phone #	Area of Specialty
Name	Phone #	Area of Specialty

Although dental hygienists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental hygiene care you will receive. Thank you for answering the following questions.

Do you have, or have you been informed that you had any of the following:

Heart Condition	Yes ☐	No ☐	Stomach or Intestinal Disease	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Artificial Joints (knee, hip...)	Yes ☐	No ☐
Respiratory Problems or Asthma	Yes ☐	No ☐	Epilepsy or Fainting	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Glaucoma or Eye Problems	Yes ☐	No ☐
Sinus Trouble	Yes ☐	No ☐	Hepatitis A/B/C/D	Yes ☐	No ☐
Have you ever used Steroids	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Hemophilia or Excessive Bleeding	Yes ☐	No ☐	Alcoholism or Drug Addiction	Yes ☐	No ☐
Cold Sores	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐
Thyroid Problems	Yes ☐	No ☐	AIDS or HIV	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Mitrovalve Prolapse	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Hormonal Imbalance	Yes ☐	No ☐
Artificial Heart Value	Yes ☐	No ☐	Kidney Problems or Dialysis	Yes ☐	No ☐
Women : Are you pregnant	Yes ☐	No ☐	Chemotherapy or Radiotherapy	Yes ☐	No ☐

Please list ALL your drug allergies: _____

Are you allergic to Latex: Yes ☐ No ☐ Any other allergies: _____

Current Medications: _____
(Please list ALL medications you take, including vitamins & herbal supplements. List on separate sheet if necessary).

Have you been hospitalized in the past 2 years for any reason? Yes ☐ No ☐

If yes, for what: _____

Do you smoke: Yes ☐ No ☐ For how many years: _____ How many packages/day: _____

Continued on page 2

Medical History page 2

Certain medical conditions require antibiotic coverage before dental hygiene care can be undertaken . If you have ever been advised that you require antibiotics prior to dental treatment please advise us immediately. If you have had any of the following:

- prosthetic heart valves,
- a prosthetic joint replacement within 2 years,
- previous bacterial endocarditis,
- unrepaired cyanotic congenital heart disease including palliative shunts and conduits, completely repaired congenital heart defect with prosthetic material or device, whether place by surgery or by catheter intervention, during the first 6 months after the procedure,
- repaired congenital heart defect with residual defects at the site or adjacent to the site of a prosthetic device
- cardiac transplantation recipients who develop cardiac vavulopathy

Please let us know if any of the conditions listed pertain to you. We may need to get an order from your physician or dentist for antibiotics and permission to carry out dental hygiene care. Please advise us PRIOR to your first appointment.

If you have ANY questions regarding the medical or dental questionnaire, please call us at 519-671-7288 or email us at pdhs08@gmail.com

GENERAL RELEASE (Please sign after completing medical and dental history forms).
I, the undersigned, certify that I have provided an accurate and complete personal, medical and dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history**. Should there be any change in either the health status or any other information I have provided, I will advise this dental hygiene office.** I authorize the dental hygienists and or dentists to perform procedures as may be required to determine necessary treatment and then to provide the necessary treatment. I give consent for Preferred Dental Hygiene Services to discuss my medical or dental health with any and all of my health providers they deem necessary to properly treat me. I give consent for my dentist, doctors, and other health care providers, including nursing home staff to release any of my medical/dental information to Preferred Dental Hygiene. I give consent for Preferred Dental Hygiene to send my insurance company my dental claims electronically or by mail, and to discuss any aspect of my dental care with the dental claims department, with regards to any dental claims submitted for me – whether the claim is assigned to them or not. Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. I have been advised that the privacy policy of Preferred Dental Hygiene Services is available online at www.pdhs.ca or that I may call or write and request a copy of the same at any time. I understand that my personal information will be collected, used and disclosed within the guidelines of this policy. I understand that responsibility for payment of the dental hygiene services for myself or my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____

(Signature) Patient ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ **(Print Name)**

Date consent signed: _____

Reviewed by Treating Dental Hygienist: _____ Date: _____