

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 |
|------|---------|-------------------|
| | | |
| | | |

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

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: _____

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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 my 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 doctors, and other health care providers, including nursing home staff to release any of my medical 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 if requested, a copy is available at the Long Term Care Facility. I also understand 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: _____