Welcome to Surana Dentistry, 812 Britannia Rd. West, Unit 108, Mississauga, ON, L5V 2W1

This form is in the care of your Dentist. This form is helpful in supporting your treatment here as a patient. Any information on this form stays in your file and is your private information.

TITLE: MR. / MRS. / MISS / MS. / DR./ OTHER____

YOUR FIRST NAME____

YOUR LAST NAME____

YOUR DATE OF BIRTH____

WHAT SEX WERE YOU BORN WITH AT BIRTH? (M/F)__________________________________

WHAT IS YOUR CURRENT GENDER IDENTITY? ____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY______________________________________

ADDRESS (HOME), DAY-TIME PHONE, AND YOUR EMAIL____________________________________

____

NAME OF FAMILY DOCTOR, PHONE & ADDRESS ____________________________________

____

NAME OF MEDICAL SPECIALIST, PHONE & ADDRESS_________________________________

____

ESTIMATED LAST DATE OF DENTAL VISIT AND REASON FOR TODAY'S VISIT_________________

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? ❑ Y E S ❑ N O ❑ NOT SURE/MAYBE

____

____

2. When was your last medical checkup? ____

3. Has there been any change in your general health in the past year? If yes, please explain.
❑Y E S ❑N O ❑NOT SURE/MAYBE

____

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
❑Y E S ❑N O ❑NOT SURE/MAYBE If yes, please list medication and reason why it is taken.

____

(We can photocopy your medication list if necessary)

5. Do you have any allergies? If you answered yes, please list using the categories below:
❑Y E S ❑N O ❑NOT SURE/MAYBE
a) Medications____
b) latex/rubber, OTHER? ____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections?
❑Y E S ❑N O ❑NOT SURE/MAYBE If yes, please explain.

____

7. Do you have or have you ever had asthma?
❑Y E S ❑N O ❑ NOT SURE/MAYBE ____

8. Do you have or have you ever had any heart or blood pressure problems?
❑YES ❑NO ❑NOT SURE/MAYBE____

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
❑YES ❑NO ❑NOT SURE/MAYBE ____

10. Do you have a prosthetic or artificial joint?
❑YES ❑NO ❑NOT SURE/MAYBE ____

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
❑YES ❑NO ❑NOT SURE/MAYBE ____

12. Have you ever had hepatitis, jaundice or liver disease?
❑YES ❑NO ❑NOT SURE/MAYBE ____

13. Do you have a bleeding problem or bleeding disorder?
❑YES ❑NO ❑NOT SURE/MAYBE ____

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
❑YES ❑NO ❑NOT SURE/MAYBE ____

15. Do you have or have you ever had any of the following? Please check.
❑ chest pain, angina ❑ rheumatic fever ❑ pacemaker ❑steroid therapy ❑ seizures (epilepsy)
❑osteoporosis ❑ heart attack ❑mitral valve ❑ lung disease ❑diabetes ❑ kidney disease medications
❑ stroke prolapse ❑tuberculosis ❑GI ulcers ❑ thyroid disease (e.g. Fosamax, ❑ shortness of breath
❑heart murmur ❑cancer ❑arthritis ❑drug/alcohol Actonel) dependency

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
❑ YES ❑NO ❑NOT SURE/MAYBE ____

17. Do you smoke or chew tobacco products? # per day for # years
❑ YES ❑NO ❑NOT SURE/MAYBE ____

18. Are you nervous during dental treatment?
❑ YES ❑NO ❑NOT SURE/MAYBE ____

19. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ❑YES ❑ NO ❑NOT SURE/MAYBE____

To the best of my knowledge, the above information is correct: By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance. Your personal health information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA. You may withdraw your consent for use or disclosure of your personal health information at any time.

I have reviewed the above information that explains how this office will use my personal health information, and the steps your office is taking to protect my information. I agree that North Eastview family dental office can collect, use and disclose personal health information as set out above in the information about the office's privacy policies.

Date __________________________________ Print name __________________________________

Signature ______________________________________

Signature of witness______________________________