Patient Medical Information

PAY CLINIC AT TOP OF INVOICE

Sunday, January 10, 2021

Last Updated:

Title _____ **First Name** x _____ **Surname** . _____

Health Card Number _____ **Email** _____

Date of birth _____ **Occupation** _____ **Employer** _____

Address _____ **Referred By** _____

_____ **Postal Code** _____

Tel Contact _____ _____

_____

Emergency Contact _____ **Emergency Contact Number** _____

Are you being treated for any medical conditions at the present time or have been treated within the last year?

Yes ☐ No ☐ Not Sure ☐

If so, why? _____

When was your last medical check-up? _____

Have there been any changes in your general health in the last year?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

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

Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

_____

_____

_____

_____

Do you have any allergies? If you answered yes, please list using the categories below:

Yes ☐ No ☐ Not Sure ☐

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had an uncommon or adverse reaction to any medicines or injections?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have or have you ever had asthma?

Yes ☐ No ☐ Not Sure ☐

Type of puffer _____

Do you have or have you ever had any heart or blood pressure problems?

Yes ☐ No ☐ Not Sure ☐

Do you have or have 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 ☐

Have you ever had hepatitis, jaundice or liver disease?

Yes ☐ No ☐ Not Sure ☐

Which type of hepatitis? _____

Do you have a prosthetic or an artificial joint?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have a bleeding problem or a bleeding disorder?

Yes ☐ No ☐ Not Sure ☐

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If yes, please explain _____

Have you ever been hospitalized for any illness or operations?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

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 ☐

Do you have or have you ever had any of the following? Please Check

☐ AIDS	☐ Digestive Disorders / Acid Reflux	☐ Hypo/Hyperglycemia	☐ Sexually Transmitted Infection
☐ Alzheimers	☐ Drug / Alcohol Dependency	☐ Kidney Disease	☐ Shortness of Breath
☐ Angina	☐ Emphysema	☐ Lung Disease	☐ Sleep Apnea
☐ Anemia	☐ Epilepsy or Seizures	☐ Lupus	☐ Steroid Therapy
☐ Arthritis	☐ Fibromyalgia	☐ Migraine	☐ Stomach Ulcers
☐ Blood Transfusion	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Stroke
☐ Cancer	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Chest Pain	☐ Heart Murmur	☐ Pacemaker	☐ Thyroid Disorder
☐ Cold Sores	☐ High/Low Blood Pressure	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Diabetes Type 1	☐ HIV	☐ Radiation/Chemotherapy	☐ Tuberculosis
☐ Diabetes Type 2	☐ Hodgkins Disease	☐ Rheumatic Fever	

Are there any conditions or disease not listed above that you have or have had?

Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have hearing problems?

Do you experience any problems with your eyes?

Do you have or ever had arteriosclerosis, artificial heart valve(s), congential heart defect, congestive heart failure (CHF), coronary artery disease (CAD), heart attack (MI), heart murmur, pacemaker or rheumatic heart disease (RHD)?

Do you suffer from depression or any other mental health disorder?

OVER 50 YEARS: Are you aware of your bone mineral density?

What would you rate your stress level (1-10)?

Do you suffer from frequent headaches?

Do you suffer from any eating disorders?

Do you suffer from Gastrointestinal esophgeal reflux disease(GERD) - acid reflux?

Has there been any significant changes in your weight?

Are you taking any vitamin or herbal supplements on a routine basis?

Are you taking any OTC medications on a routine basis?

DENTAL: Are any of your teeth sensitive to HOT, COLD, PRESSURE or SWEETS?

Last Updated:

DENTAL: Do you have removable dental appliances and/or implants?

DENTAL: Do you have any difficulty swallowing?

DENTAL: Do you experience dry mouth?

DENTAL: If smoking is YES, Have you ever tried or been comtemplating on quitting?

DENTAL: Do you use an electric or manual toothbrush? If manual, is it soft, medium or hard bristles?

DENTAL: Do you use anything to clean between the teeth like floss, toothpicks, proxa brush, rubber tip or sulca brush?

DENTAL: What kind of toothpaste are you presently using?

DENTAL: What is the major concern that brings you in today and what are your dental health goals?

CONSENT: I consent to my claims being submitted electronically if permissable and available and acknowlege that I am responsible for my account and any unpaid balances from my insurance carrier.

CONSENT: I have read and understand the privacy policy set out by Dental Hygiene Connections Corp. and consen to this oral health service.

I WOULD LIKE TO DECLINE MY EXAM AND XRAYS TODAY, I AM AWARE THE IMPLICATIONS AND ACCEPT RESPONSIBILITY FOR UNFORSEEABLE EVENTS BY NOT COMPLETETING THESE FOR PROPER DIAGNOSIS.

ASA CLASS?

Last Updated:

No changes in Medical History?

DIABETES INSULIN CONTROLLED: WHAT WAS YOUR LAST GLUCOSE READING AND WHEN?

DO YOU HAVE AN INFECTIOUS DISEASE SUCH AS C.DIFF, MRSA, TB, VRE+, OR SARS?

DO YOU ANY SYSTEMIC CONDITION THAT WOULD AFFECT YOUR IMMUNE SYSTEM?

How often do you have bowel movement? (Once day/Twice/Weekly?)

How much water or fluids do you drink daily?

How much alcohol (beer/wine or spirits) do you drink on weekly basis?

What is your chief complaint (any problems with your teeth/gums)?

What is your diet?

Hygienist Ms. Corinne Strohman **Tel** 403-993-7031
Address 4411 - 16 Avenue NW
Suite 140
CALGARY Alberta T3B 0M3 Canada

The Information I have given above is true to the best of my knowledge

Patient Signature _____ **Date** _____

Last Updated:

PHIA permits us to collect and use your personal health information. In certain circumstances, PHIA also allows us to share it with others both inside and outside our organization. We do this for purposes such as:

To provide you with health care;

To get payment for your care which could include private insurers;

To do health system planning and research;

To report as required by law;

Unless you tell us not to, we can share your personal health information with any health care provider who has, is or will be providing you with health care. Members of your health care team are only allowed access to the information they need to give you the care you need. If you tell us not to share your information with a health care provider, we will not share your information unless permitted or required by law to do so. Please tell a member of your health care team if you do not want your information shared with a health care provider.