DAYAN DENTISTRY

Medical/Dental History

709 – 2300 Yonge Street
Toronto, ON, M4P 1E4
(416) 322-3233
info@dayandentistry.com

Patient Name	Medical Alert (for office only)
Preferred Name Title	

Age _____ Birth Date _____ Gender ☐ M ☐ F Marital Status ☐ Married ☐ Single ☐ Other ☐ Child
day / month / year

Address _____ City _____ Province _____ Postal Code _____

Phone Home _____ Work _____ Mobile _____ Best time to call _____

Preferred method of contact? ☐ Phone ☐ SMS ☐ Email How did you hear about us? _____

What is the reason for your visit today?

Prior Dentist's name, address & phone number

When was your last visit to the dentist and what treatments were done?

Did you have x-rays taken?

How often do you have dental visits?

How frequently do you brush your teeth?

☐ 3 (+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth?

☐ 1 (+) a day ☐ 2 - 6 Weekly ☐ 1 - 6 Monthly ☐ Seldom ☐ Never

Do you use water pick?

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Please check any of the following to indicate **Yes** in response to the question:

- [ ] Are any of your teeth currently causing you pain?
- [ ] Do your teeth experience sensitivity to cold or hot temperatures?
- [ ] Do your teeth experience any sensitivity to chewing?
- [ ] Do you grind your teeth (either consciously or during sleep)?
- [ ] Do your gums bleed when you brush or floss?
- [ ] Are any of your teeth loose, or are you concerned about any teeth loosening?
- [ ] Do you ever experience dry mouth or unpleasant taste in your mouth?
- [ ] Have you ever been to a periodontist?
- [ ] Have you lost any teeth, if yes why?
- [ ] Any complications with extractions?
- [ ] Have you ever been to an orthodontist?
- [ ] Do you have any retainers?
- [ ] Do you currently have any dental implants, dentures, or partials?
- [ ] Do you have any veneers, crowns or bridges?
- [ ] Did you whiten your teeth?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

Are you currently under the care of a physician due to a specific condition? If yes, please describe

Within the last year, have their been any changes in your general health?

Have you ever been hospitalized due to a surgery or illness? If yes, please describe

What is the date (or approximate date) of your last medical exam?

Are you currently taking any prescription or non-prescription medication? If yes, please list

Your Primary Care Physician's name, address & phone number

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Please check any of the following to indicate Yes in response to the question:

- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you use recreational drugs?
- ☐ Do you consume alcohol?
- ☐ Do you require the use of corrective lenses (contacts or glasses)?

WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No

If Yes, when is the due date?

Please check to indicate Yes if you have experienced any of the following:

- ☐ *Pre-Medication
- ☐ *See Patient Notes
- ☐ Allergy - *See Notes
- ☐ Allergy-Aspirin
- ☐ Allergy-Codeine
- ☐ Allergy-Iodine
- ☐ Allergy-Latex
- ☐ Allergy-Penicillin
- ☐ Allergy-Sulfa
- ☐ Allergy-Erythromicin
- ☐ Allergy-Local Anesth
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Cancer
- ☐ Dental Phobia
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Excessive Bruising
- ☐ Gastro-Intestinal
- ☐ Glaucoma
- ☐ Hard to Freeze
- ☐ Head Injury
- ☐ Hearing Disabled
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV+ (AIDS)
- ☐ Hives
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Multiple Sclerosis
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Rheumatoid Arthritis
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Smoker
- ☐ STD
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Wheelchair

Do you have any other health issues or allergies?

Have you ever had complications following dental treatment? If Yes, please describe

☐ To the best of my knowledge, all of the preceding information is true and correct.
If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

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WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No

If Yes, when is the due date?

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize my dentist to release my information including the diagnosis and records of treatment or examination for myself and dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I understand that I am financially responsible for the outstanding balance for services provided, including those that are not fully covered by insurance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for by cash, debit, MasterCard, or Visa at the time services are performed.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of three months from are date of the patient examination.

In consideration for the professional service rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature _____ Date _____ (day / month / year) Relationship to patient _____