MEADOWBROOK

DENTAL CENTRE

613-546-6865

open Monday to Thursday 8am to 4pm, Friday 8am to 3pm

HEALTH / INSURANCE QUESTIONNAIRE

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept in strict confidence unless allowed or required by law. Your written permission will be required to release any information.

DATE _______________

SURNAME ______________________________ GIVEN NAME ______________________________

Date of Birth: Month _____ Day _____ Year _____ Sex: F ☐ M ☐

Primary Phone # _______________ Cell/Work # _______________

Address ____

City ______________________________ Postal Code _______________

Email Address ______________________________ Confirm your appointments via email? Yes ☐ No ☐

Emergency Contact (Name) ______________________________ Phone # _______________

Relationship ______________________________

Dental Insurance? Yes ☐ No ☐ Insurance Company ______________________________

Employer ______________________________ Policy # ______________________________

Division ______________________________ Subscribers I.D. # ______________________________

Cardholder's Name ______________________________ Date of Birth _______________

If you were referred to our office, whom may we thank? ______________________________

Last Dental Exam (Date) _______________

Have you ever been referred for general anesthesia, intravenous, or nitrous oxide sedation? Yes ☐ No ☐

Are you nervous or anxious during dental treatment? Yes ☐ No ☐

Please check off if you have any of the following concerns:

☐ Toothache ☐ Extraction Required ☐ Sore Gums ☐ Implants ☐ Dentures

☐ Wisdom Teeth ☐ Crown/Bridge Work ☐ Regular Check-up ☐ Dental Cleaning ☐ Broken Filling/Tooth

Medical History

Health Card # ______________________________ Physician ______________________________

Height _______________ Weight _______________

1) Are you presently being treated by a physician? Yes ☐ No ☐

2) Last Medical Exam (Date) _______________

3) Are you taking any prescribed medications, non-prescription drugs, or herbal supplements of any kind? Yes ☐ No ☐

If yes, name, dose and frequency ____

4) Do you smoke or chew tobacco? Yes ☐ No ☐

5) Do you drink alcohol? Yes ☐ No ☐

6) Recreational Drugs _______________

7) If female, are you pregnant? Yes ☐ No ☐

8) Do you snore or have been told you stop breathing while asleep? Yes ☐ No ☐

9) Have you ever been hospitalized? Yes ☐ No ☐ If yes, why? ______________________________

10) Do you have a prosthetic heart valve? Yes ☐ No ☐

11) Do you have a pacemaker? Yes ☐ No ☐

12) Any previous surgery? Yes ☐ No ☐ If yes, what? ___________________________

13) Have you ever had radiation treatment to your head or neck? Yes ☐ No ☐

14) Is there any condition that we should be aware of that would assist us with your treatment? _______________

15) Have you ever had or been treated for the following?

☐ Liver Disorder ☐ Kidney Disorder ☐ Heart Attack ☐ Diabetes ☐ Acid Reflux

☐ Endocarditis ☐ High Blood Pressure ☐ Seizure Disorder ☐ Breathing Problems ☐ Osteoporosis

☐ Anemia ☐ Stroke ☐ Angina ☐ Cancer ☐ Thyroid Problems

☐ Hepatitis ☐ Artificial Joints ☐ Bleeding Problems

16) Are you allergic to any of the following?

☐ Penicillin ☐ Latex ☐ Steroids ☐ Barbiturates ☐ Local Anesthetics

☐ Tetracycline ☐ Aspirin ☐ Erythromycin ☐ Codeine ☐ Valium/Benzodiazepines

☐ Metals ☐ Foods ☐ Other ____

The information I have given above is true and to the best of my knowledge.

____ Patient or Guardian Signature