Dentistry on Sherbrooke
Family & Cosmetic Dentistry

Welcome to our office. Please fill out this form completely in ink. All information is strictly confidential.

Medical Alert

Patient Information

Name: ______ Birth date: ______ Today's date: ______

Address: ______ City: ______ Postal Code: ______

Home Ph. ______ Cell Ph. ______ Work Ph. ______ Email: ______

Occupation: ______ Employer: ______

Dental Insurance Co.: ______ Group # ______ Certificate # ______

Person to contact in case of emergency: ______ Relationship: ______ Ph. ______

Is any other member of your family a patient at our office? ______

How did you hear about our office? ______ Whom may we thank for referring you? ______

Patient Medical History

Physician: ______ Ph. ______

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

	Y	N		Y	N		Y	N		Y	N
Allergy to latex	☐	☐	Bypass surgery	☐	☐	Heart murmur	☐	☐	Psychiatric condition	☐	☐
Allergy to medication	☐	☐	Cancer	☐	☐	Heart disease/surgery	☐	☐	Rheumatic fever	☐	☐
Angina/chest pain	☐	☐	Cardiac pacemaker	☐	☐	Hepatitis	☐	☐	Sinus trouble	☐	☐
Arthritis	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐	Stroke	☐	☐
Artificial heart valve	☐	☐	Drugs/alcohol dependency	☐	☐	HIV/AIDS	☐	☐	Thyroid disease	☐	☐
Artificial joint	☐	☐	Epilepsy/seizures	☐	☐	Kidney disease	☐	☐	Other ______		
Asthma	☐	☐	Fainting spells	☐	☐	Liver disease	☐	☐	______		
Bleeding disorder	☐	☐	Heart attack	☐	☐	Lung disease	☐	☐	______		

Please give details about any items indicated above: ______

Please list all medications you are taking: ______

List any drugs/medications you are allergic to: ______

Females Only: Are you currently pregnant or breast feeding? ______

Describe any other medical condition that you think may impact on dental care: ______

Patient Dental History

Name of previous dentist: ______ Date of last visit: ______

Describe any dental pain/discomfort: ______

Describe what you would like done with your teeth: ______

I certify that I have answered the above accurately. I hereby consent to the performing of those dental procedures mutually agreed upon, and agree to assume full responsibility for fees associated with these services.

Patient's (Parent's) signature ______ *Date* ______

Office Financial Policy

It is our policy that services are paid for at each visit as they are rendered. In certain circumstances, arrangements for payment may be made by consulting the office manager or dentist.