YORK & BAY DENTAL OFFICE

This questionnaire was designed to provide important facts regarding your health history that will assist in reaching a diagnosis and treating you safely. PLEASE PRINT.

PATIENT INFORMATION **TODAY'S DATE** (DD/MM/YY): ____ / ____ / ____

NAME:_______________________________________ Date of Birth (DD/MM/YY): ____ / ____ / ____

Address: ____ Email:__________________________

City:___________________________ Province:________________ Postal Code:_____________________

Phone CELL:__________________ WORK:_________________________ HOME:___________________

Medical Doctor: ___________________________ Phone/Address_________________________________

Medical Specialist: _________________________ Area of Specialty________________________________

Medical Specialist: _________________________ Area of Specialty________________________________

Emergency Contact (name + phone #):____

How did you hear about us (ex. Google, coworker, signage, parents etc.)?__________________________

DENTAL INSURANCE

Policy Holder NAME: ______________________________ Birthdate (DD/MM/YY): ____ / ____ / ____

Insurance Co:_____________________________ Employer: ______________________________________

POLICY/GROUP#_____________________________ ID#_____________________________ DIV#_______

SECONDARY DENTAL INSURANCE (if applicable)

Policy Holder NAME: ______________________________ Birthdate (DD/MM/YY): ____ / ____ / ____

Insurance Co:_____________________________ Employer: ______________________________________

POLICY/GROUP#_____________________________ ID#_____________________________ DIV#_______

AUTO INSURANCE (if applicable)

Policy Holder Name____________________________ Relationship to Policy Holder__________________

Policy Holder Address____

POLICY#___________________________CLAIM#____

Insurance Co.___________________________ City of Branch Office_______________________________

Adjuster name____________________________

Adjuster's Phone No (_____) ______-_________ ext_____ Adjuster's Fax No (____)_____-________

ARE YOU ALLERGIC TO: (CHECK IF YES)

Penicillin ___ Aspirin___ Anesthetic (Freezing) ___ Codeine___ Latex____ Other____________

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (PLEASE ATTACH SHEET FOR MORE SPACE)

MEDICATION	REASON	MEDICATION	REASON
1)______________________	______________________	4)______________________	______________________
2)______________________	______________________	5)______________________	______________________
3)______________________	______________________	6)______________________	______________________

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITION OR HAVE YOU BEEN TREATED WITHIN THE PAST YEAR? ___ Yes ___ No Explain if yes ____________________________________

WHEN WAS YOUR LAST MEDICAL CHECK UP? ____

DO YOU HAVE A FAMILY HISTORY OF (check if yes): ___ Diabetes ___ Cancer ___Heart Disease

ARE YOU NERVOUS ABOUT DENTAL TREATMENT? ____

HAVE YOU EVER HAD OR EXPERIENCED…(CHECK IF YES AND SPECIFY THE APPROXIMATE YEAR)

YES	CONDITION	NOTES
___	Blood pressure problems	____________________
___	Chest pain (angina)	____________________
___	Shortness of breath	____________________
___	Heart attack	____________________
___	Stroke, TIA	____________________
___	Heart murmur	____________________
___	Rheumatic fever	____________________
___	Mitral valve prolapse	____________________
___	Heart surgery	____________________
___	Heart valve replacement	____________________
___	Pacemaker	____________________
___	Bleeding Problems	____________________
___	Pregnant/Breastfeeding	____________________
___	Asthma	____________________
___	Smoking/Vaping (past/present)	____________________
___	Drug/Alcohol/Cannabis use	____________________
___	Tuberculosis	____________________
___	Lung disease	____________________

___ Stomach ulcers ____

___ Anorexia/Bulimia ____

___ Autoimmune Disorders ____

___ Arthritis ____

___ Joint Replacement ____

___ Steroid therapy ____

___ Diabetes ____

___ Thyroid disease ____

___ Cancer/Cancer treatment ____

___ Anxiety/Mental Health Issues ____

___ Child/Spousal Abuse ____

___ Seizures (epilepsy) ____

___ AIDS/HIV/STD ____

___ Hepatitis ____

___ Kidney disease ____

___ Osteoporosis meds (ex Fosamax, Actonel) ____________________________________

___ Concussion/Head injury ____

___ Car Accident ____

___ Snoring/Sleep Apnea ____

___ Alzheimer's/Dementia ____

CONSENT

1. Consultation with your medical doctor may be necessary to assure safe dental treatment
2. Some dental insurance companies request information such as copies of X-rays or specific dental information to determine coverage.
3. The patient (guardian) is responsible for all costs and should be reimbursed by their insurance carriers according to the contract of their dental plan.

To the best of my knowledge the above information is correct. I hereby allow York & Bay Dental Office to obtain/release information, as noted above, and as required:

Patient/Parent/Guardian: ___________________________ DATE (mm/dd/yy):____________

Dentist Signature: _________________________________ DATE (mm/dd/yy):____________