NEW PATIENT MEDICAL INFORMATION

1935 Bank St. | 613-520-0222 | osmilesfamilydental.ca

Please complete all sections. If you are unsure, select “Not sure.”

PATIENT INFORMATION

Title _____ **First Name** _____

Surname _____ **Health Card Number** _____

Email _____ **Date of birth** _____

Occupation _____ **Employer** _____

Address _____ **Referred by** _____

Postal Code _____ **Home phone** _____

Work phone _____ **Mobile** _____

Emergency Contact _____ **Emergency Contact Number** _____

MEDICAL HISTORY

Are you being treated for any medical conditions now, or have you been treated within the last year? ☐ Yes ☐ No ☐ Not sure

If yes, please explain / list: _____

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 / list: _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ Yes ☐ No ☐ Not sure

If yes, please explain / list: _____

Do you have any allergies? ☐ Yes ☐ No ☐ Not sure

Medications _____

Latex / rubber products _____

Other allergies _____

Have you ever had an uncommon or adverse reaction to any medicines or injections? ☐ Yes ☐ No ☐ Not sure

If yes, please explain / list: _____

Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not sure

Do you have or have you ever had any heart or blood-pressure problems? ☐ Yes ☐ No ☐ Not sure

Have you ever had a heart-valve replacement or repair, infective endocarditis, 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 artificial joint? ☐ Yes ☐ No ☐ Not sure

If yes, please explain / list: _____

Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not sure

If yes, please explain / list: _____

Have you ever been hospitalized for any illness or operation? ☐ Yes ☐ No ☐ Not sure

If yes, please explain / list: _____

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

Ottawa SMILES FAMILY Dental

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CONDITIONS & HEALTH HISTORY

Do you have or have you ever had any of the following? Please check all that apply.

☐ AIDS	☐ Alzheimer's disease	☐ Angina
☐ Anemia	☐ Arthritis	☐ Blood transfusion
☐ Cancer	☐ Chest pain	☐ Cold sores
☐ Diabetes Type 1	☐ Diabetes Type 2	☐ Digestive disorders / acid reflux
☐ Drug / alcohol dependency	☐ Emphysema	☐ Epilepsy or seizures
☐ Fibromyalgia	☐ Head / neck injury	☐ Heart attack
☐ Heart murmur	☐ High / low blood pressure	☐ HIV
☐ Hodgkin's disease	☐ Hypo-/hyperglycemia	☐ Kidney disease
☐ Lung disease	☐ Lupus	☐ Migraine
☐ Mitral valve prolapse	☐ Osteoporosis medications (e.g., Fosamax, Actonel)	☐ Pacemaker
☐ Parkinson's disease	☐ Radiation / chemotherapy	☐ Rheumatic fever
☐ Sexually transmitted infection	☐ Shortness of breath	☐ Sleep apnea
☐ Steroid therapy	☐ Stomach ulcers	☐ Stroke
☐ Thrush	☐ Thyroid disorder	☐ TMJ disorder
☐ Tuberculosis		

Are there any conditions or diseases not listed above that you have or have had? ☐ Yes ☐ No ☐ Not sure

If yes, please explain / 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 / list: _____

LIFESTYLE & DENTAL CARE

Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not sure

How often do you use tobacco and for how long? _____

Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not sure

Are you pregnant? ☐ Yes ☐ No ☐ Not sure

Do you drink alcohol? ☐ Yes ☐ No ☐ Not sure

If yes, how often do you drink? _____

Dentist _____ **Telephone** _____

Address _____

CONSENT & PRIVACY

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

Privacy notice (PHIPA)

Ontario's Personal Health Information Protection Act, 2004 (PHIPA) permits us to collect, use and disclose personal health information as authorized by law. We use your information to provide health care, obtain payment (including from insurers), support permitted health-system activities, and meet legal or regulatory requirements. Unless you tell us otherwise, we may share relevant information with health-care providers involved in your care when permitted by PHIPA. Please speak with our team if you have questions or wish to discuss limits on sharing.

Patient / Guardian Signature _____ **Date** _____