Barrie Dental Specialists

34 Quarry Ridge Rd, Suite 200 • Barrie, ON L4M-7G1 (705)722-1104

BDS Medical & Dental History Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

I would like to spend some time with you to record your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Name of referring dentist and dental office *

Why have you been referred to Barrie Dental Specialists? *

Would you consider yourself to be in; *

☐ Excellent health ☐ Good health ☐ Fair health ☐ Poor health

Within the past year, have there been any changes in your general health? If yes, please elaborate. *

☐ Yes ☐ No ☐ Not Sure/Maybe

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

Your Primary Care Physician's Name. Address and Phone #:

Health Card Number #

Nearest Pharmacy Name, Address and Phone #

Are you currently being treated for any medical condition? If yes, please describe. *

☐ Yes ☐ No ☐ Not Sure/Maybe

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them *

☐ Yes ☐ No ☐ Not Sure/Maybe

Do you have any allergies? If yes, please list them below. *

☐ None
☐ Medications
☐ Latex/Rubber products
☐ Other (e.g. hay fever, seasonal/environmental foods)

Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. *

☐ Yes ☐ No ☐ Not Sure/Maybe

Do you smoke or chew tobacco products?
If Yes, for how many years and how many packs a day?
If No, when did you quit? *

☐ Yes ☐ No ☐ Never

Do you have or have you ever had Asthma? *

☐ Yes ☐ No ☐ Not Sure/Maybe

Do you have or have you ever had any heart or blood pressure problems? *

☐ Yes ☐ No ☐ Not Sure/Maybe

What is your Blood Pressure (Typically)? _____

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or heart transplant? *

☐ Yes ☐ No ☐ Not Sure/Maybe

_____

_____

_____

Do you have a prosthetic or artificial joint? *

☐ Yes ☐ No ☐ Not Sure/Maybe

_____

_____

_____

Do you require pre-medication prior to dental treatment? ☐ Yes ☐ No

Type of Pre-medication:

_____

_____

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

- ☐ Chest pain/Angina
- ☐ Acid Reflux
- ☐ Rheumatic fever
- ☐ Cancer
- ☐ Jaundice
- ☐ Lung disease
- ☐ Arthritis
- ☐ Thyroid disease
- ☐ kidney disease
- ☐ Heart attack
- ☐ Elevated Cholesterol
- ☐ Mitral valve prolapse
- ☐ Bleeding disorder
- ☐ Hepatitis A, B,C
- ☐ Shortness of breath
- ☐ Steroid therapy
- ☐ Drug/alcohol/ cannabis use or dependency
- ☐ Osteoporosis medications
- ☐ Stroke, TIA
- ☐ Heart murmur
- ☐ Tuberculosis
- ☐ Liver disease
- ☐ Pacemaker
- ☐ Stomach ulcers
- ☐ Diabetes
- ☐ Seizures (epilepsy)

Details:

If you have Diabetes, when was your most recent A1C Test completed? _____

What was your most recent A1C Test result? _____

What is your typical A1C Test result? _____

Are there any conditions or diseases not listed previously that you have or have had? If yes, please explain *

☐ Yes ☐ No ☐ Not sure/Maybe

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/Maybe

Have you ever been hospitalized for any illness or operations? if yes, please explain. * ☐ Yes ☐ No

Are there any diseases or medical problems that run in your family (e.g., diabetes, cancer or heart disease)? *

☐ Yes ☐ No ☐ Not sure/Maybe

Are you nervous during dental treatment? *

☐ Yes ☐ No ☐ Not sure/Maybe

Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? *

☐ Yes ☐ No ☐ Not sure/Maybe

Expected delivery date: _____

What is important to you about your oral health? *

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

Is there anything else we should know regarding your past dental history, including any specific concerns? *

Do you identify as a patient with a disability? If yes, how may we best assist you in our dental practice? * ☐ Yes ☐ No

☐ * **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.**

Authorization

☐ * **I hereby certify that I have been provided with 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 the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.**

☐ * **I understand that Barrie Dental Specialists is a fee for service dental specialty practice and 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).**

Response Date:_____