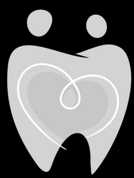


ROBERTSON
FAMILY DENTISTRY

Phone: (613) 829-2222
info@robertsonfamilydentistry.ca
www.robertsonfamilydentistry.ca

# UPDATED INFORMATION

## PERSONAL INFORMATION        Today's Date:_

| | | | |
|---|---|---|---|
| First Name | | Last Name | |
| Please Circle One | Male Female | Mr. Mrs. Ms. Miss. Dr. | |
| Address | | | |
| City | | Postal Code | |
| Birth Date | | Email | |
| Home Phone | | Cell Phone | Allow SMS<br>YES NO |
| Place of Employment | | Work Phone | |
| Emergency Contact not living with you: | | Phone | |

## PHYSICIAN INFORMATION

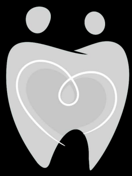
| | | | |
|---|---|---|---|
| Name of Physician | | Phone | |
| Address of Physician | | Date of last Physical Exam | |

## DENTAL INFORMATION

| | | |
|---|---|---|
| Are your teeth experiencing any discomfort or pain at this time? What? | ❑ Yes | ❑ No |
| Do you require any pre-medication for my dental visits? Why (include dates)? | ❑ Yes | ❑ No |
| Do you frequently get food caught between any teeth? Where? | ❑ Yes | ❑ No |
| Please circle if you have or have you had any of the following: **clenching** **grinding** **jaw pain** **popping sounds** **limited opening** **locking** **sensitivity** | | |
| Are you interested in: Teeth Whitening or Straightening of Teeth (Invisalign) | ❑ Yes | ❑ No |

## MEDICAL INFORMATION

| | | |
|---|---|---|
| Are you in good general health? | ❑ Yes | ❑ No |
| List ALL Medical Conditions and Allergies: | ❑ None | |
| Please list **ALL** current medications, **dosage** and **reason** for usage: | ❑ None | |
| Have you been hospitalized or had any serious illness or operation ever? If yes, when, what? | ❑ Yes | ❑ No |
| Have you ever a positive test from COVID-19? If yes which Date:_________________ | ❑ Yes | ❑ No |



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Please circle if you have had an allergic reaction or reacted to any of the following: **Local anaesthetics** **Antibiotics** **Penicillin** **Sulfa drugs** **Barbiturates** **Sedatives** **Aspirin** **Tylenol** **Sleeping pills** **Codeine** **Demerol** **Latex (eg. rubber gloves)**

Please circle if you have had any of the following: **Cardiac Pacemaker** **Tuberculosis** **Sinusitis** **Emphysema** **Chronic Bronchitis** **Asthma** **Sinus trouble** **Stomach ulcers** **Hepatitis** **HIV** **Jaundice** **Diabetes** **Thyroid trouble** **Anemia** **Sickle Cell disease** **Blood disorders** **Hemophilia** **Glaucoma**

| | | |
|---|---|---|
| Do you have chest pain after exertion? | ❑ Yes | ❑ No |

Please circle have ever had: **Epilepsy** **Fainting Spells** **Seizures** **Emotional disturbance**

| | | |
|---|---|---|
| Do you follow any treatment for behavioural diseases? | ❑ Yes | ❑ No |
| Is there any family history of blood disorders? | ❑ Yes | ❑ No |
| Have you had abnormal bleeding after any surgery, extraction or trauma? | ❑ Yes | ❑ No |
| Have you ever had a blood transfusion? When? | ❑ Yes | ❑ No |

Please circle if you have or have you ever had? **Arthritis** **Inflammatory Rheumatism** **Bone Infection** **Osteoporosis** **Kidney trouble** **Venereal disease** **Exposure to HIV virus** **AIDS** **Tumor** **Chemotherapy** **Radiation therapy** **Cancer**

| | | |
|---|---|---|
| Do you have artificial joints? What and date of placement: | ❑ Yes | ❑ No |
| Do you smoke or use tobacco? If yes, how many times a week? | ❑ Yes | ❑ No |
| Do you drink alcohol? If yes, how much in a week? | ❑ Yes | ❑ No |
| Do you consume any recreational substances? If yes, what and how often? | ❑ Yes | ❑ No |
| Are you pregnant or nursing? | ❑ Yes | ❑ No |

Is there anything in your medical and dental history that we have not specifically asked about that we should be made aware of ? If so, Please explain:______________________________________________

______________________________________________

______________________________________________

## RESPONSIBILITY & CONSENT FORM

I hereby authorize and request the performance of dental services for myself or any of my dependents. I also give my consent to the advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for dental treatment or diagnostic purpose. These records may include study models, photographs or x-rays. I understand and acknowledge that I am financially responsible for the services provided for myself or any of my dependants, regardless of the insurance coverage. I also understand that the treatment estimate presented to me is only an estimate and occasionally, the need may arise to modify treatment. I believe the information given in the previous pages of the medical and dental history to be true to the best of my knowledge.

Signature of Patient or Guardian: ______________________________ Date : ____________________________