

Dr. Michele Pakozdi

Suite 103 - 460 Main Street East, Hamilton, Ontario L8N 1K4

Patient's Name _____
Surname First Middle Initial

Date of Birth _____
Month Day Year

Address _____ Apt.# _____

City _____ Postal Code _____

Telephone: Home: _____ Business: _____ Ext.# _____

Occupation/Employer: _____

Who referred you to our office? _____

Do you have "Dental Insurance"? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Birth: _____
Name of Insurance Company: _____	Policy #: _____
Policy Holder: _____	Division #: _____
Relationship of patient to policy holder: _____	I.D or Certification #: _____
Secondary Coverage:	
Policy Holder: _____	Carrier: _____
	Birth Date: _____
Policy #: _____	Certificate #: _____

Emergency Contact: Name: _____ Relationship: _____
Phone Number: _____

Physician's Name & Phone Number: _____
Do you have any medical condition(s) requiring antibiotics before your dental treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what is the condition? _____
When was your last medical check up? _____
Have there been any changes in your general health in the past year? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please explain: _____

Please list all current medications including prescription and non-prescription drugs and herbal supplements, especially St. John's Wort, flax seed, flax seed oil, chinese mushroom: _____ _____ _____
Do you have any allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> If you answered yes, please list using the categories below:
a) medications: _____
b) latex/rubber products: _____
c) other (ex. hayfever, foods): _____

Have you ever had an unusual or adverse reaction to any medications or injections? Yes No

If yes, please explain: _____

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 a heart transplant? Yes No

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiation therapy, chemotherapy? Yes No

Have you ever had a joint replacement? Yes No

Have you ever been hospitalized for any illnesses or operations? Yes No

If yes, please explain: _____

Do you have or have you ever had any of the following? Please check if yes:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Bypass surgery | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Head/Neck injuries | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Osteoporosis medications
(ex. Fosamax, Actonel) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Chest pain, angina | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bleeding problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Car accident injuries | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Drug/Alcohol dependency |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Migraines | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy (seizures) |

Do you smoke or chew tobacco products? Yes No

Is there any other information we should know about your health? _____

For women only: Are you breastfeeding or pregnant? Yes No Not Sure/ Maybe

If pregnant, what is the expected delivery date? _____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions about my medical history. I authorize the dentist to perform procedures and treatment as may be necessary and understand this treatment is for my immediate problem, and should not be regarded as a complete examination with resulting treatment. I assume responsibility for fees associated with these services and authorize release of any information regarding my diagnosis or treatment to my dentist or my physician.

(Signature) Patient Parent Guardian Date: _____

(Print Name of Guardian) Date: _____

Signature of Dentist: _____ Date: _____

Signature: _____ Date: _____
Parent's Signature (for children under 18 years of age)

Signature of Dentist: _____ Date: _____

Signature: _____ Date: _____
Parent's Signature (for children under 18 years of age)

Signature of Dentist: _____ Date: _____