BURLINGTON PROSTHODONTICS
CERTIFIED SPECIALISTS
IMPLANT, ESTHETIC & RECONSTRUCTIVE DENTISTRY

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For Office Use Only:

Consult Date: _____

MEDICAL HISTORY QUESTIONNAIRE (3 Pages)

MEDICAL ALERT: _____

○ ○ ○ ○ ○

Title: MR./ MISS/ MRS./ MS./ DR. First Name: _____ Last Name: _____

How would you prefer to be called in this office? _____

DATE OF BIRTH (DAY/MONTH/YEAR): _____/_____/_____

ADDRESS (HOME): _____ City: _____ Prov: _____ Postal Code: _____

HOME PHONE: _____ CELL: _____ EMAIL: _____

ADDRESS (BUSINESS): _____

OCCUPATION: _____ WORK PHONE: _____

WHO REFERRED YOU TO OUR OFFICE? _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____ RELATIONSHIP: _____

DAY-TIME PHONE: _____

NAME OF FAMILY DOCTOR: _____ PHONE OR ADDRESS: _____

(1) MEDICAL SPECIALIST: _____ AREA OF SPECIALITY: _____

PHONE OR ADDRESS: _____

NAME OF GENERAL DENTIST: _____

ADDRESS: _____ PHONE NUMBER: _____

ARE THERE OTHER DENTAL SPECIALISTS INVOLVED IN YOUR CARE? ❑ YES ❑ NO

IF YES PLEASE PROVIDE: NAME: _____

ADDRESS: _____ PHONE NUMBER: _____

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? ❑ YES ❑ NO ❑ NOT SURE/MAYBE
   If YES, why? _____

2. When was your last medical check-up? _____

3. Has there been any change in your general health in the past year? ❑ YES ❑ NO ❑ NOT SURE/MAYBE
   If yes, please explain. _____

4. Are you taking any prescription medications? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

If YES, please list:

_____

_____

5. Are you currently taking any over the counter (non-prescription) medications or herbal supplements of any kind? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

If yes, please list. _____

6. Do you have any allergies? If you answered yes, please list using the categories below: ❑ YES ❑ NO ❑ NOT SURE/MAYBE

a) Medications b) latex/rubber products c) other (e.g. hayfever, foods)

7. Have you ever had a peculiar or adverse reaction to any medicines or injections? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

If yes, please explain. _____

8. Do you have or have you ever had asthma? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

9. Do you have or have you ever had any heart or blood pressure problems? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

10. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

11. Do you have a prosthetic or artificial joint? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

12. 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

13. Have you ever had hepatitis, jaundice or liver disease? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

14. Do you have a bleeding problem or bleeding disorder? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

15. Have you ever been hospitalized for any illnesses or operations? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

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

❑ chest pain, angina	❑ mitral valve prolapse	❑ cancer	❑ seizures (epilepsy)	❑ osteoporosis medications
❑ heart attack	❑ heart murmur	❑ steroid therapy	❑ kidney disease	(e.g. Fosamax, Actonel)
❑ stroke	❑ pacemaker	❑ diabetes	❑ thyroid disease	
❑ shortness of Breath	❑ lung disease	❑ stomach ulcers	❑ drug/alcohol dependency	
❑ rheumatic fever	❑ tuberculosis	❑ arthritis		

17. Are there any conditions or diseases not listed above that you have or have had? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

If yes,what?_____

18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ❑ YES ❑ NO ❑ NOT SURE/MAYBE

19. A) Do you smoke or chew tobacco products? ❑ YES ❑ NO

B) Have you smoked in the past? ❑ YES ❑ NO

If yes, When did you quit? _____

20 A.) How nervous are you during dental treatment? **Not at all** ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10 **Terrified**

B.) Would you like to consider/discuss sedation for treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

21. Do you consume alcoholic drinks? ❑ YES ❑ NO

If YES, how many per week? _____

22. Do you need premedication for dental treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

23. **For women only:** Are you breastfeeding or pregnant? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

If pregnant, what is the expected delivery date? DUE DATE (DAY/MONTH/YEAR)_____/_____/_____

24. **Please mark YES or NO in response to the following questions:**

Do your gums bleed when you brush or floss?	❑ YES	❑ NO
Do your teeth experience sensitivity to cold or hot temperatures?	❑ YES	❑ NO
Are any of your teeth currently causing you pain?	❑ YES	❑ NO
Do you grind your teeth (either consciously or during sleep)?	❑ YES	❑ NO
Are any of your teeth loose, or are you concerned about any teeth loosening?	❑ YES	❑ NO
Do you currently have any dental implants, complete dentures, or partial dentures?	❑ YES	❑ NO

If any of the previous questions are marked YES, please explain:

_____

_____

25. **What is your main concern and reason for your dental visit today?**_____

_____

_____

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

_____

_____

To the best of my knowledge, the above information is correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization
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 and necessary.
I authorize the prosthodontist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers and/or healthcare practitioners necessary for my dental care.
I understand that I am responsible for submitting my insurance pre-determinations / estimates of treatment related to my dental care in this office and that I will discuss and communicate directly with my insurance company if necessary.
I understand that, as a courtesy, this office may provide me with printed standard predetermination forms pertaining to my anticipated treatment plan and submit electronic claims when my treatment is completed.
I agree to provide at least 2 business days' notice to reschedule/cancel my appointment or a fee will apply.
I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependent(s) (if any).

Please fill out this form electronically and email to **reception@burlingtonprosthodontics.com** or print the completed the form and bring to your initial consultation. Thank you.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

DATE (DAY/MONTH/YEAR) _____/_____/_____

Relationship to Patient: _____

DOCTOR'S SIGNATURE: _____

DATE (DAY/MONTH/YEAR) _____/_____/_____