

Medical alert
(office use only)

Patient I.D. #

EDI

WELCOME TO KING RITSON DENTAL!

Adult Information

Dr. Mr. Mrs. Ms. Miss

Date: ____ \ ____ \ ____
M D Y

Name: _____
(last) (first) (initial)

Address: _____
(street) (city) (province) (postal code)

Date of Birth: ____ \ ____ \ ____ Age: _____ Sex: _____ Marital Status: _____
M D Y

Home Phone: (____) _____ Business Phone: (____) _____ Ext. _____

Email Address: _____

Driver's License # _____ Social Insurance # _____

Family Physician: _____ Phone: (____) _____

Medical Specialist #1 (if presently under care) _____ Phone: (____) _____

Medical Specialist #2 (if presently under care) _____ Phone: (____) _____

Child Information

Name: _____ Prefers to be called: _____
(last) (first) (initial)

Address: _____
(street) (city) (province) (postal code)

Date of Birth: ____ \ ____ \ ____ Age: _____ Sex: _____ Home Phone: (____) _____
M D Y

Family Physician: _____ Phone: (____) _____

Medical Specialist (if presently under care) _____ Phone: (____) _____

School _____ Grade: _____

If the child's name and/or address is different than yours, or if you are the child's guardian, please complete the Adult Information section also.

Person Responsible for Account

Self Other Name: _____
(last) (first) (initial)

Address: _____
(street) (city) (province) (postal code)

Home Phone: (____) _____ Business Phone: (____) _____ Ext. _____

Driver's License # _____ Social Insurance # _____

Occupation: _____

Employed By: _____ Phone: (____) _____ Ext. _____

Spouse Employed By: _____ Phone: (____) _____ Ext. _____

Dental Insurance: Yes No Group Policy #: _____ Certif. #: _____

Insurance Company Name: _____

Amount of Coverage: Basic _____% Prosthetics _____% Crown/Bridge _____% Ortho _____% Perio Scaling _____%

Secondary Insurance: _____ Group Policy #: _____ Certif. #: _____

Amount of Coverage: Basic _____% Prosthetics _____% Crown/Bridge _____% Ortho _____% Perio Scaling _____%

In Case of Emergency

Please Notify: _____ Relationship: _____

Home Phone: Phone: (____) _____ Business Phone: Phone: (____) _____ Ext. _____

Is any other member of your family or relative a patient at our office?

Sons: _____

Daughters: _____

Spouse: _____ Other: _____

Reason for Today's visit: Examination Emergency Other: _____

Whom may we thank for referring you to this office? _____

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Pre-Medicate

Name: _____ (last) (first) (initial)

Medical History

Present Physician: _____ Phone: (____) _____

Specialist Physician: _____ Phone: (____) _____

Are you presently under Doctor's care? Why? _____ Yes No

Have you been under Doctor's care in the past two years? Why? _____ Yes No

Have you taken any medications, pills or drugs in the past two years? _____ Yes No

Are you presently taking any medications, pills or drugs? _____ Yes No

If yes, what? _____

Have you been hospitalized in the past two years? _____ Yes No

If yes, what? _____

When was your last complete physical examination? _____

When walking, do you ever have to stop because of pain in your chest or shortness of breath? Yes No

Have you ever had any type of surgery? Yes No

If yes, what and when? _____

Are you on a prescription diet? Yes No

Have you ever been diagnosed as having a tumor or cancer? Yes No

Have you ever taken cortisone/steroid medication? Yes No

Do you wish to speak privately to the Doctor about any problem? Yes No

Do you experience problems with healing? Yes No

Do you smoke? Yes No

If yes, how much? _____

Are you currently in good health? Yes No

Has any family member had any medical conditions? Yes No

Allergies

Please check off any medications you are allergic to or you have reacted adversely to:

- Medication allergy checkboxes: Numbutal, Aspirin, Tylenol, Tylenol #1, #2, #4, 222, 282, 292, Food Allergies, Ibuprofen (Advil), Seconal, Naproxen, Toradol, Codeine, Demerol, Percodan, Darvon, Penicillin, Amoxicillin, Ampicillin, Erythromycin, Clindamycin, Scopolamine, Tetracycline, Rovamycin, Cedhalexin, Sulfa Drugs, Metal, Latex, Local Anaesthetic (Freezing), Nitrous Oxide, Valium, Chlorhexidene (Peridex)

Please list any other medications or substances which you know you are allergic to: _____

Medical Conditions

Please check off any of the following conditions you presently have or have had.

- Medical condition checkboxes: Heart Failure, High Blood Pressure, Low Blood Pressure, Heart Murmur, Rheumatic Fever, Scarlet Fever, Congenital Heart Lesion, Artificial Heart Valve, Heart Pacemaker, Heart Surgery, Anemia, Mitral Valve Prolapse, Cardiac Arrest/Heart Attack, Hypertension, Abnormal Bleeding, Drug or Alcohol Addiction, Chest Pain, Angina Pectoris, Shortness of Breath, Swelling of Feet/Ankles/Hands, Fainting or Dizziness, Stroke, Diabetes or Hypoglycemia, Artificial Joints/Hips, Kidney Trouble, Ulcers, Allergies, Cosmetic Surgery, Malignant Hyperthermia, Tattoos, Asthma, Hay Fever, Sinus Trouble, Emphysema, Frequent Cough, Lung Disease, Bronchitis, Tuberculosis, Liver Disease, Hepatitis A (infect.), Hepatitis B (serum), Hepatitis C, Yellow Jaundice, Transdermal Nicotine Patches, Cancer, Thyroid Disease, X-Ray or Cobalt Treatment, Chemotherapy/Radiation, Arthritis/Gout, Rheumatism, Pain in Jaw Joints, Cortisone/Steroids, Glaucoma, Epilepsy or Seizures, Glandular Disorders, Mental/Nervous Disorders, Psychiatric Care, Bleeding Problems, Blood Transfusion, Hemophilia, AIDS (HIV Positive), Venereal Disease, Cold Sores, Fever Blisters, Herpes, Bruise Easily, Sickle Cell Anemia, Blood Disorders, Circulation Problems, Head/Neck Injuries, Stomach/Intestinal Problems

Please list in detail any other serious illness not shown above which you have or may have had: _____

Women Only

Are you pregnant? Yes No Due Date: _____

Are you taking birth control pills? Yes No

Child Patient Only

- Child patient checkboxes: Measles, Mumps, Chicken Pox, Strep Throat, Tonsillitis, German Measles

Please indicate approximate date: _____

Medical Updates

NOTE: It is important that you notify our office of any change in your medical status

Since my last visit, my Medical History as noted on this chart (has) or (has not) changed.

Table with 5 columns: DATE, DETAILS, HAS, HAS NOT, PATIENTS SIGNATURE, REVIEWED BY