Blood Pressure
_____
FOR DENTIST USE ONLY

NEWCASTLE SMILE DENTAL CENTRE

ASA Classification
_____
FOR DENTIST USE ONLY

Medical History Questionnaire

Patient Name: _____ Date of Birth: _____

Address: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Other: (___)_____

E-mail: _____ Name of Pharmacy Most Commonly Used _____

Emergency Contact: _____
Name Relationship Phone

Family Doctor: _____
Name Location Phone Date of Last Exam

1: Are you currently being treated or have you been treated for any medical conditions in the last 9 months? ☐ Y ☐ N

Please Explain: _____

2: Are you taking any medications or non-prescription drugs? ☐ Y ☐ N

Please List: _____

3: Do you have any known allergies? ☐ Y ☐ N

Please Specify: _____

4: Have you ever had an adverse reaction to any medications or injections? ☐ Y ☐ N

Please Explain: _____

5: Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Y ☐ N

6: Do you have or have you ever had any of the following (please circle appropriate condition):

Hepatitis, jaundice, liver disease	Y	N	Bleeding problem, bleeding disorder	Y	N
Prosthetic or artificial joint or valve	Y	N	Congenital heart disease, prosthetic cardiac valve	Y	N
Infective endocarditis, cardiac transplant	Y	N	High/low blood pressure, stroke	Y	N
Chest pain, angina or heart attack	Y	N	Immune system: leukemia, AIDS/HIV infection	Y	N
Asthma, shortness of breath, lung disease	Y	N	Pacemaker	Y	N
Seizures/epilepsy	Y	N	Arthritis	Y	N
Stomach ulcers	Y	N	Diabetes (Type 1 or 2)	Y	N
Cancer (type, when) _____	Y	N	Kidney disease	Y	N
Thyroid Disease	Y	N	Steroid therapy	Y	N
Tuberculosis	Y	N	Drug or alcohol disease	Y	N

7: Do you currently use tobacco products _____ Y N

8: For women only: Are you pregnant, trying to get pregnant or breastfeeding? _____ Y N

Notes: _____

_____

General Release

I the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. Should there be any changes in my health status in the future, I will advise the dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another healthcare provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependants is mine and I assume the responsibility for fees associated with these services.

Patient/Guardian Signature Print Name Date

Reviewed by Date Reviewed By Date

Spousal Approval

I hereby authorize the release of my treatment information to my spouse

Signature of patient

Consent to SMS messaging, text and e-mail

I hereby authorize the dental office to text or e-mail regarding my upcoming appointments and or treatment.

Signature of patient

ESA APPROVAL

I hereby authorize the release of information contained in claims to be submitted electronically to my insuring company plans administrator.

Signature of patient/parent/guardian

Client# _____ Date _____

Checked by _____

PRIVACY APPROVAL

I hereby certify that I have been notified of the privacy policies of this office, who to contact regarding concerns and to request further information.

Signature of patient/parent/guardian

Client# _____ Date _____

Checked by _____

Newcastle Smile Dental Centre Cancellation/Missed Appointment Policy

Your appointment time is reserved exclusively for you. We ask for a minimum of 2 business days notice should you need to reschedule in order to avoid any missed appointment fees.

Please Initial that you have read: _____