beamsville smiles
FAMILY DENTISTRY

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 circle any of the following which you have had or have currently:

Alcohol or Drug abuse	Diabetes	Latex Allergy
Anemia or Hemophilia	Epilepsy or Seizures	Liver Disease
Arthritis	Fainting of Dizzy Spells	HIV or Aids
Artificial Heart Valve/Joints	Heart Murmur	Radiation Therapy
Asthma	Heart Problems	Respiratory Disease
Cancer or Tumor	Hepatitis	Rheumatic Fever
Chemotherapy	High blood pressure	Sinus Problems
Cold Sores	Kidney Disease	Stroke
High Cholesterol	Osteoporosis	Thyroid Disease

Other medical Conditions (not listed above): _____

_____

Physician's Name: _____ Phone Number: _____

Have you been under the care of a specialist during the last two years: YES NO

If yes, for what reason? _____

Have you ever been told you need to be pre-medicated prior to dental work? YES NO

Are you currently taking any natural supplements, prescription or over-the-counter drugs? YES NO

If yes, please list all supplements/medications and dosage:

_____

_____

Do you have any allergies to any medications? _____

Any other known allergies? _____

Do you currently use a form of tobacco? YES NO How much per day? _____

Are you currently using marijuana either medicinally or recreationally? YES NO

Women Only: Are you, or do you think you may be pregnant? YES NO Due Date: _____

Are you currently nursing an infant? YES NO

Name:_____ Date of Birth:_____/_____/_____
M D YYYY

Signature:_ _____ Date: : _____/_____/_____
M D YYYY