Day-Op Dental Anesthesiology
Medical History

1- 279 Kingston Rd E. Ajax, ON L1Z 0K5 905-683-3300

Date: _____

Name: _____ Address: _____

City_____Province_____Postal Code_____Phone (H)_____(W) _____

Date of Birth_____Sex_____Weight_____Occupation _____

Email_____**Health Card Number** _____

Closest Relative_____Phone_____

School/Employer_____Physician (Name, Telephone#)_____

Insurance Information

Are you a recipient of Ontario Works or Ontario Disability? Yes θ No θ

If you answered yes above, please state which program. _____

First Company:	Second Company:
Name of Insured:	Name of Insured:
Date of Birth:	Date of Birth:
Employer:	Employer:
Policy Number:	Policy Number:
I.D. Number:	I.D. Number:

For the following questions, indicate yes or no, whichever applies. Your responses are for our records only and will be considered in confidence. Please respond to each question carefully.

General Health	Yes	No	Comments
1. Are you in good health?	θ	θ	_____
2. Do you exercise regularly?	θ	θ	_____
3. Are you ill now or were you recently ill?	θ	θ	_____
4. Do you or did you ever smoke? (Quantify in packs/day for ? years)	θ	θ	_____
5. Do you drink alcohol? (How much?)	θ	θ	_____
6. Do you have a recent productive cough?	θ	θ	_____
7. Do you have sleep apnea?	θ	θ	_____
8. Women: Could you be pregnant?	θ	θ	_____
9. Are you ALLERGIC to any medication? (list)	θ	θ	_____

10. LIST ALL MEDICATION YOU NOW TAKE _____

_____

11. Have you taken any other medication in the past 2 years? (list)_____

12. Do you belong to any group at high risk for contact with any infectious diseases? (e.g. HIV, hepatitis) θ θ _____

Medical History

Yes No Comments

13. Have you had any problems with your nerves? (Frequent and/or severe headaches, epilepsy, seizures, strokes, numbness of arms or legs, head and neck or facial injury, extreme nervousness or anxiety, psychiatric illness.)
θ θ _____

14. Do you have or have you had any problem with your heart? (Describe the nature of the problem, e.g., chest pain, high blood pressure, heart attack, abnormal ECG, skipped beats, sleeping with more than one pillow, ankle swelling, waking up at night short of breath.) θ θ _____

15. Do you have or have you had any problems with your lungs or chest? (Describe the nature of the problem, e.g. shortness of breath, chest pain, emphysema, bronchitis, asthma, TB, abnormal chest X-ray.)
θ θ _____

16. Have you or anyone in your family had a serious problem with their blood? (anemia, prolonged bleeding from nose, teeth gums, and/or surgery, sickle cell anemia, blood transfusions.)
θ θ _____

17. Do you have diabetes?(Do you wake up at night to urinate; excessive thirst?)
θ θ _____

18. Have you had any problem with your:

Liver (cirrhosis, jaundice, malaria) ? θ θ _____

Kidney (stones, infection, failure, dialysis) ? θ θ _____

Thyroid gland θ θ _____

Digestive system (heartburn, hiatal hernia, ulcer) ? θ θ _____

19. LIST ALL MEDICAL ILLNESSESS_____

_____

20. LIST ALL OPERATIONS _____

_____

Anesthesia

21. Have you or any blood relative had problems with anesthesia and surgery? (nausea and vomiting, hyperthermia, prolonged drowsiness, anxiety?) θ θ _____

22. Do you have any problems with motion sickness? θ θ _____

23. Do you have any particular concern about your anesthesia? (anxiety, fears, questions)
θ θ _____

24. Do you have any chipped or loose teeth, denture, caps, bridgework?
θ θ _____

25. Have you taken any "street drugs" (marijuana, cocaine) within the last two weeks?
θ θ _____

26. Additional comments: _____

_____

Signature (Patient/Legal Guardian) Date (YY/MM/DD)

Reviewed by Phone θ In-Person θ Date_____Time_____

Vital signs: BP_____ PP_____ RR_____ T_____ Weight (kg) _____

Comments: _____

Appointment Scheduling and Confirmation

E-mail confirmation of your appointment is a service we provide, however, you are ultimately responsible to maintain your scheduled appointment if you are unable to be contacted. If you find that you are unable to keep your scheduled appointment, we require **72 HOURS (3business days)** notice so that we may accommodate the dental needs of another patient. If an appointment is broken without 72hours notice, a fee will be applied to your account. **We do not take cancellation of appointments on our answering machine.** You need to call during office hours. **If you would prefer to no longer receive electronic messages from our office, please respond to this email with the word 'Unsubscribe' in the subject line.**

Office Hours

Monday – Thursday - 8:00am – 4:00pm
Friday - 8:00am – 1:00pm
Saturday –Sunday - Closed

I understand that a fee will be charged for missed appointments by myself (or my children) where at least 72 hours' notice is not provided. If I also come unprepared for my appointment resulting in a cancellation, there will be a charge applied to my account that must be paid before another appointment is scheduled.

The undersigned hereby consents to the collection and use of personal information about me or my children in accordance with The Personal Information Protection and Electronic Documents Act. I have had the opportunity to review the office Personal Protection Policy at my request.

Print name of patient or guardian: _____

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Witness Date