Hopedale Shopping Centre 2nd floor
1515 Rebecca Street, Suite 220
Oakville, Ontario, L6L 5G8
www.oakdaledental.ca 905 827-0301

Welcome to the office of Dr Steven Rosenblat

Family, Cosmetic and Implant Dentistry

MEDICAL ALLERT FOR OFFICE

NAME; MR. / MISS / MRS / MS. / DR.

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

ADDRESS (HOME):

PHONE: (H) (W)

(CELL)

(EMAIL)

OCCUPATION:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

OR, DID YOU HEAR OF US FROM : INTERNET / YELLOW PAGES / SIGN / NEWSPAPER / OTHER:

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

HEIGHT WIEGHT

❑ MALE ❑FEMALE AGE TODAY

❑ DENTAL INSURANCE COMPANY NAME:

GROUP POLICY # : CERTFICATE #:

❑ SECONDARY INSURANCE COMPANY NAME:

GROUP POLICY # : CERTFICATE #:

AFTER COMPLETING ALL PAGES OF THIS QUESTIONAIRE PLEASE READ AND SIGN THE AUTHORIZATION AND RELEASE BELOW:

I certify that I have read, understood and accurately completed the personal, medical and dental questionnaires to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed by me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical questions. I authorize Dr. Rosenblat or his employees to release any information concerning my dental treatment or my child's dental treatment to third party payers and /or other medical/dental offices. I authorize Dr. Rosenblat and his qualified employees to perform necessary diagnostic procedures and treatment as required to achieve the proper level of dental care including the use of local anesthesia and other medication as indicated. I understand that I am financially responsible to the dentist for all costs of dental services provided, regardless of outcome, even if my insurance coverage may not be all inclusive.

PATIENT / PARENT / GUARDIAN SIGNATURE: DATE:

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MEDICAL HISTORY QUESTIONNAIRE

NAME: DATE:

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. Dr. Rosenblat 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? If so, why?
❑ YES ❑ NO ❑ NOT SURE / MAYBE

2. When was your last medical checkup?

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

4. Are you taking any medications, non prescription drugs or herbal supplements of any kind? If yes please list them all.
❑ YES ❑ NO ❑ NOT SURE / MAYBE

5. Do you have any allergies? If you answer yes, please list using the categories below: ❑ YES ❑ NO ❑ NOT SURE / MAYBE
   a. Medications: i.e.. aspirin dental anesthetics
   b. latex / rubber products codeine metals
   c. other (e.g. hay fever, foods…) penicillin

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
❑ YES ❑ NO ❑ NOT SURE / MAYBE

7. Have you ever been hospitalized for any illness or operations? If yes, please explain. ❑ YES ❑ NO ❑ NOT SURE / MAYBE

8. Do you smoke or chew tobacco products? ❑ YES ❑ NO

9.. For women, are you breastfeeding or pregnant? ❑ YES ❑ NO . If pregnant delivery date is:

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NAME: DATE:

10. Do you have or have you ever had any of the following? Please check.

❑Asthma
❑Heart problems
❑Blood pressure problems
❑Artificial heart valve
❑Heart infection
❑Heart condition from birth
❑Bleeding disorders
❑Heart defects
❑Heart transplant
❑Artificial / prosthetic joints
❑Immune deficiencies

❑AIDS
❑HIV
❑Liver disease
❑Hepatitis
❑Leukemia
❑Cancer
❑Radiation therapy
❑Chemotherapy
❑Chest pains, angina
❑Heart attack
❑Stroke

❑Shortness of breath
❑Rheumatic fever
❑Mitral valve prolapse
❑Heart murmer
❑Pacemaker
❑Lung disease
❑Tuberculosis
❑Steroid therapy
❑Diabetes
❑Stomach ulcers
❑Arthritis

❑Seizures (epilepsy)
❑Kidney disease
❑Drug/alcohol dependency
❑Osteoporosis medications (e.g. Fosamax, Actonel)
❑Thyroid problems

11. Are there any conditions or diseases not listed above that you have had? If so, what?

❑ YES ❑ NO ❑ NOT SURE / MAYBE

DENTAL HISTORY QUESTIONNAIRE

Are you nervous during dental treatment? ❑ YES ❑ NO

When was you last dental visit?

What is the reason for today's visit?

Do you love your smile?

Is there anything you would like to change?

Why did you leave your last dentist?

Do you have any missing teeth you would like to replace?❑ YES ❑ NO

Do you have:

❑Any pain
❑Loose teeth
❑Teeth that have shifted
❑Sensitive teeth to:
❑Hot ❑cold ❑sweet ❑biting

❑Gum swelling?
❑Bleeding gums?
❑Shifting teeth?
❑Jaw pain
❑Clicking/popping jaw

Have you ever had:

❑Root canal
❑Teeth removed
❑Gum surgery
❑Implants
❑Complications after extractions
❑Problems with local anesthetics

Thank you for completing these forms.