

AGAPE DENTAL CLINIC

#103, 2603 Hewes Way, Edmonton, AB T6L 6W6

Patient Name: _____ Date: _____
Last First MI

Gender: _____ D.O.B: ____/____/____ Family status: _____
D M YR

Address: _____
Postal Code _____

Phone (Home): _____ (Work): _____ EMAIL Address: _____

We require the following information to enable us to provide you with the best possible dental care. The information provided will be kept strictly private, and is protected by doctor-patient confidentiality. Your dentist will review the questions and explain any that you do not understand. Please fill the entire form.

1. Are you under care of a Physician? YES NO

2. Name of your Family Physician: _____ Phone: _____

3. When was your last medical check up? Why?

4. Have there been any changes in your general health over the past year? If yes, explain.

YES NO MAYBE/NOT SURE _____

5. Are you taking any prescription drugs, non-prescription drugs or herbal supplements? If yes, please list.

YES NO MAYBE/NOT SURE _____

6. Do you have any allergies?

YES NO MAYBE/NOT SURE _____

If yes, please circle

Penicillin Aspirin Advil Latex Sulfa drugs Codeine Others

7. Have you ever been admitted to a hospital or needed emergency care?

YES NO MAYBE/NOT SURE _____

8. Have you ever had any adverse reaction to any medication or injections? If yes please explain

YES NO MAYBE/NOT SURE _____

9. Have you ever had complications during/following dental treatment? If yes please explain

YES NO MAYBE/NOT SURE _____

10. Do you have a bleeding problem or bleeding disorder? If yes, please explain

YES NO MAYBE/NOT SURE _____

11. Are you nervous during dental treatment?

YES NO

12. Have you ever had any of the following listed below? Please circle.

- | | | | |
|-------------------|---------------------|----------------------|------------------|
| AIDS | Epilepsy | Kidney disease | Stomach problems |
| Allergies | Fainting | Liver disease | Stroke |
| Anemia | Glaucoma | Mental disorders | Syphilis |
| Artificial joints | Hay fever | Nervous disorders | Tuberculosis |
| Arthritis | Head injuries | Pacemaker | Tumors |
| Asthma | Heart disease | Radiation | |
| Cancer | Heart murmur | Respiratory problems | |
| Diabetes | Hepatitis/Jaundice | Rheumatic fever | |
| Dizziness | High blood pressure | Sinus problems | |

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

YES NO MAYBE/NOT SURE _____

14. Are there any diseases or medical problems that run in your family?
(e.g. diabetes, cancer, blood pressure, heart disease)

YES NO MAYBE/NOT SURE _____

15. For women only: Are you pregnant or breast-feeding? If pregnant, how many weeks into pregnancy?

YES NO MAYBE/NOT SURE _____

Insurance Company: _____

Policy Holder: _____ **DOB:** _____

Policy/Group/Contract #: _____ **ID/Certificate #** _____

As our office accepts assignment of benefits from dental insurance companies, please be aware that our office does not follow any insurance fee schedule. It is the sole responsibility of the policy holder to inform our office of any limitations on the plan coverage. As dental professionals, we strive to provide quality care and treatment for our patients, we will not be dictated by insurance companies.

All the information provided above is true to the best of my knowledge. If I ever have any change in my health, I will inform my dentist at the next appointment without fail.

Signature of Patient/Parent/Guardian: _____ Date: _____