DAY	MONTH	YEAR

EMERGENCY TREATMENT ENVELOPE

Patient ID# ____________

In an effort to serve you better we would ask that you complete the following information. We will be glad to help if you need assistance. **PLEASE PRINT.**

PATIENT INFORMATION

A Parent or Guardian will be responsible for decisions relating to my treatment Yes ☐ No ☐

Name: ____
First Initial Last

Address: ____
Street Apt. City Prov. Postal Code

Date of Birth: _____/_____/_____ Home Tel: (_____)__________ Work Tel: (_____)__________
D M Y

Family Dr. ______________________ Tel: (_____)__________

Emergency Contact: ______________________ Tel: (_____)__________

FINANCIAL INFORMATION

This account will be paid by Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐

Person responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐ **(Please fill out if different than above)**

Name: ____
First Initial Last

Address: ____
Street Apt. City Prov. Postal Code

Date of Birth: _____/_____/_____ Home Tel: (_____)__________ Work Tel: (_____)__________
D M Y

Driver's Lic.: ______________________ **OR** ID #: _______ - _______ - _______

INSURANCE INFORMATION (If applicable)

Insurance Company: ______________________ Tel: (_____)__________

Employer/Group Policy Holder ______________________ Insurance Year End: __________

Policy #: __________ Certificate #: __________ ID #: __________

Max. Coverage: __________ % Coverage for: __________ Basic __________ Major Restorative. __________ Orthodontic

MEDICAL HISTORY (this information will remain confidential)

	YES	NO
1. Are you presently under the care of a physician? If so explain ______________	☐	☐
2. Have you ever had a serious illness or been hospitalized? If so explain ______________	☐	☐
3. Are you taking any drugs or medication at this time? Drug __________ Reason __________	☐	☐
4. Do you suffer from any allergies (hay fever, latex etc.)? If so which ones? ______________	☐	☐
5. Do you bruise easily or have prolonged bleeding?..............................	☐	☐
6. Have you ever fainted, had shortness of breath or chest pains?	☐	☐
7. Have you ever been warned against using any medication? If so which?______________	☐	☐
8. Have you ever taken prolonged medical or non-medical drugs? Specify ______________	☐	☐

9. Have you ever had an adverse effect to any of the following: **Aspirin** ☐, **Barbiturates** (sleeping pills)☐ **Antibiotics** -(Penicillin ☐, Sulfonamide ☐, other ☐), **Codeine** ☐, **Darvon** ☐, **Local Anaesthetic** ☐

10. **Women:**: Are you pregnant? Yes ☐ No ☐ Have you reached menopause? Yes ☐ No ☐ Are you taking birth control? Yes ☐ No ☐

11. Do you or have you ever had any of the following: **Please ☑ appropriate boxes**

☐ A.I.D.S	☐ Cancer	☐ Heart disease/attack	☐ Jaundice	☐ Rheumatic/Scarlet fever
☐ Anemia	☐ Circulation problems	☐ Heart murmur	☐ Kidney disease	☐ Sickle cell disease
☐ Angina pectoris	☐ Congenital heart lesions	☐ Heart pacemaker/surgery	☐ Liver disease	☐ Sinus Trouble
☐ Anorexia nervosa	☐ Cortisone/steroid	☐ Heart rhythm disorder	☐ Leukemia	☐ Stomach/intestinal prob.
☐ Arthritis/rheumatism	☐ Diabetes	☐ Hepatitis A/B/C	☐ Lung Disease	☐ Stroke
☐ Artificial heart valve	☐ Drug/Alcohol dependence	☐ Herpes	☐ Malignant hyperthermia	☐ Thyroid disease
☐ Artificial joints (hip, knee)	☐ Emphysema	☐ High/Low Blood Pressure	☐ Mental/nervous disorder	☐ Tuberculosis
☐ Asthma	☐ Epilepsy or seizures	☐ H.I.V. Positive	☐ Mitral valve prolapse	☐ Ulcers
☐ Blood Disorders	☐ Glandular disorders	☐ Hodgkins disease	☐ Organ transplant/implant	☐ Venereal disease
☐ Bronchitis	☐ Glaucoma	☐ Hyper (Hypo) Glycemia	☐ Psychiatric treatment	☐ Other __________
☐ Bulimia	☐ Head/neck injuries	☐ Hypertension	☐ Radiation/Chemotherapy	☐ **None**

12. **Children Only:** Have you recently had any of the following (approximate date): ☐ Chicken Pox __________
☐ Measles __________ ☐ Mumps __________ ☐ Strep Throat __________ ☐ Tonsillitis __________

DENTAL HISTORY

1. What is the reason for today's visit? ______________________
2. When was your last dental visit? __________ Last X-Ray? __________
3. Have you ever had local anaesthetic (freezing)? ☐ Yes ☐ No Any complications? ☐ Yes ☐ No Specify __________

GENERAL RELEASE: I, the undersigned, understand that the information contained in the dental and medical history portion of this chart is important to my treatment. I certify that the information is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.