Dr. Alan Fernandes • Dr. Robert Pacione

MEDICAL ALERT (Office use only) _____ PATIENT I.D. # _____

PATIENT INFORMATION

Name: _____
(last) (first) (initial)

Address: _____
(street) (apt #) (city) (prov.) (postal code)

Date of Birth: ____/____/____ Age: _____ Sex: _____ Marital Status: _____
Day Month Year

Home Phone: ( ) _____ Bus. Phone: ( ) _____ Ext. _____

Cell: ( ) _____ Other: ( ) _____

Family Physician: _____ Phone: ( ) _____

Medical Specialist #1 (if presently under care) _____ Phone: ( ) _____

Person responsible for account

AS ABOVE ☐

Name: _____
(last) (first) (initial)

Address: _____
(street) (city) (prov.) (postal code)

Occupation _____

Employed by: _____ Phone: ( ) _____ Ext. _____

Spouse employed by: _____ Phone: ( ) _____ Ext. _____

In Case of Emergency

Please notify: _____ Relationship _____

Phone: ( ) _____ Bus. Phone: ( ) _____ Ext. _____

Is any member of your family or relative a patient at our office?

Sons _____

Daughters _____

Spouse _____ Other _____

Reason for today's visit

☐ Examination ☐ Emergency ☐ Other _____

Whom may we thank for referring you to this office? _____

MEDICAL HISTORY

Are you presently under Doctor's care? Why?_____ Yes ☐ No ☐

Are you presently taking any medications, pills or drugs?_____ Yes ☐ No ☐

(If yes, what?) _____

Have you been hospitalized in the past two years?_____ Yes ☐ No ☐

(If yes, why?) _____

Do you experience problems with healing? _____ Yes ☐ No ☐

Have you ever had any type of surgery? _____ Yes ☐ No ☐

(What & when?)_____

Do you smoke? _____ Yes ☐ No ☐, If yes, how much? _____

Have you ever been diagnosed as having a tumor or cancer? _____ Yes ☐ No ☐

Have you ever taken cortisone/steroid medication? _____ Yes ☐ No ☐

Has any family member had any serious medical condition? _____ Yes ☐ No ☐

ALLERGIES

Please check off any medications you are allergic to:

☐ Aspirin	☐ Naproxen	☐ Penicillin	☐ Sulfa Drugs	☐ Local Anaesthetic
☐ Tylenol	☐ Toradol	☐ Amoxicillin	☐ Latex	(Freezing)
☐ Ibuprofen (Advil)	☐ Codeine	☐ Other Antibiotics		☐ Nitrous Oxide

Food allergies, please list:_____

Please list any other medications or substances which you know you are allergic to:_____

MEDICAL CONDITIONS

Please check off any of the following conditions you presently have or have had.

☐ High Blood Pressure	☐ Anaemia	☐ Artificial Joints/Hips	☐ Lung Disease	☐ Epilepsy or Seizures
☐ Low Blood Pressure	☐ Mitral Valve Prolapse	☐ Kidney Trouble	☐ Bronchitis	☐ Mental/Nervous
☐ Heart Murmur	☐ Cardiac Arrest/	☐ Ulcers	☐ Tuberculosis	Disorders
☐ Rheumatic Fever	Heart Attack	☐ Stomach/Int. Probl.	☐ Liver Disease	☐ Hemophilia
☐ Scarlet Fever	☐ Hypertension	☐ Allergies	☐ Hepatitis A/B/C	☐ AIDS (HIV Positive)
☐ Congenital Heart	☐ Angina Pectoris	☐ Malignant Hyper-	☐ Cancer	☐ Venereal Disease
Lesion	☐ Fainting or Dizziness	thermia	☐ Thyroid Disease	☐ Herpes
☐ Artificial Heart Valve	☐ Stroke	☐ Asthma/Hayfever	☐ Arthritis/Gout	☐ Sickle Cell Anaemia
☐ Heart Pacemaker	☐ Diabetes or Hypo-	☐ Sinus Trouble	☐ Rheumatism	☐ Blood Disorders
☐ Heart Surgery	glycemia	☐ Emphysema	☐ Glaucoma	☐ Head/Neck Injuries

Drug or Alcohol Addiction, if Yes, have you received treatment? _____

Please list in detail any serious illness not shown above which you have or may have had: _____

WOMEN ONLY:

Are you Pregnant? _____ Yes ☐ No ☐ Due Date: _____ Are you taking birth control pills? _____ Yes ☐ No ☐

GENERAL RELEASE STATEMENT

I certify that I have read, understood and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with 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 question. I authorize the dentist to perform necessary diagnostic procedures and treatment as required to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

Patient ☐ Parent ☐ Guardian ☐ Date _____ Signature _____