Banwell Dental Centre- Dr. Rob Trajkovski DDS

3335 Banwell Rd. Unit #300 • Windsor, ON N8N-0B4 (519)956-7779

Medical & Dental History Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
☐ Are you currently taking any prescription or non-prescription medications?
☐ Do you use tobacco (smoking or chewing)?
☐ Do you require the use of corrective lenses (contacts or glasses)?
☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

- ☐ *Pre-Medication
- ☐ Allergy - Aspirin
- ☐ Allergy - Penicillin
- ☐ Allergy-Local Anesth
- ☐ Asthma
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ HBP
- ☐ Head Injury
- ☐ Hepatitis A
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Skin Rash
- ☐ Thyroid Disease
- ☐ Wheelchair
- ☐ *See Patient Notes
- ☐ Allergy - Codeine
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Blood Disease
- ☐ Dizziness/Fainting
- ☐ Excessive Bruising
- ☐ HIV+ (AIDS)
- ☐ Hearing Disabled
- ☐ Hepatitis B
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Radiation Treatment
- ☐ Rheumatoid Arthritis
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Afib
- ☐ Allergy - Iodine
- ☐ Allergy-Clavulin
- ☐ Arthritis
- ☐ Cancer
- ☐ Emphysema
- ☐ Gastro-Intestinal
- ☐ Hard To Freeze
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ LBP
- ☐ Nervous Disorders
- ☐ Respiratory Problems
- ☐ STD
- ☐ Stroke
- ☐ Tumors
- ☐ Allergy - *See Notes
- ☐ Allergy - Latex
- ☐ Allergy-Erythromicin
- ☐ Artificial Joints
- ☐ Contraceptive Use
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Hives
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ TMJ
- ☐ Ulcers

Do you have any other health issues or allergies?

_____

_____

_____

What is the reason for your dental visit today?

_____

_____

When was your last visit to the dentist (if to a different office)?

_____

_____

Prior Dentist's name, address, & phone number:

_____

_____

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

_____

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

☐ **By checking this box, I acknowledge that I have read and agree to this Authorization.**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. As consistent with applicable laws and the policies of the patient's applicable dental insurance or other third-party payer coverage, we require the following:

All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

All dental services are charged directly to the patient and the patient is personally responsible for payment of all dental services, even if the patient carries dental insurance. This office will, as a courtesy, help prepare the patient's insurance forms and may assist in making collections from dental insurance companies, and will credit any collections from insurance to the patient's account.

Fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Payment for services is due at the time of treatment, or if billed by this office, payment is due within thirty (30) days of billing.

Charges for services shall be as billed unless objected to, by the patient, in writing, within the time payment is due.

☐ **By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Name and relationship to patient:

_____

_____

Response Date: _____