Emergency Treatment Information

Name_____Date_____

Residence Address_____City_____

Province_____ Postal Code_____ Tel. Res. #_____

Bus.#_____Cell.#_____Sex_____Birthdate_____

Referred By_____Occupation_____

Employer_____ email address_____

Name of Physician_____Healthcar#_____

Name of Dental Ins._____ Policy#_____

ID#_____

Confidential Medical History ----Please check the appropriate square

	Yes	No
Are you presently under the care of a physician?		
Is your health perfect?		
Are you taking any medication or drugs?		
Have you been warned against taking any medicines or chemicals?		
Have you any allergies, hay fever or asthma?		
Have you ever experienced any unusual reaction to local or general anesthesia?		
Do you bruise easily or have prolonged bleeding?		
Do you have any disorders?		
Have there been any recent changes in your weight, thirst, or appetite?		
Have you ever had any injury, surgery or radiation therapy to your head, face or jaws?		
Have you had any major surgery?		

If you have ever had or been treated for any of the following, please circle
Rheumatic fever, hepatitis, scarlet fever, diphtheria, tuberculosis or lung disease, diabetes, heart attack or heart disease, stroke, epilepsy, gall bladder disease, liver or kidney disease, high blood pressure, cancer.

For women only
Are you pregnant? If so, what month?_____

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable including the use of general anesthetic as indicated and I will assume responsibility for fees associated with those procedures.

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Signature of Patient or Guardian