

# Medical History Update

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt/Unit#: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ ext: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ (mm/dd/yyyy)  
 E-mail address: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

May we send you emails about important office notifications, including appointment reminders?  Yes  No  
 May we send you text message appointment reminders?  Yes  No You have the option to withdraw your consent at any time.

**Please check any PAST or PRESENT medical conditions**

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Heart condition                  | <input type="checkbox"/> HIV positive/AIDS           | <input type="checkbox"/> Cancer - type: _____           | <input type="checkbox"/> Vision Impairment             |
| <input type="checkbox"/> Angina                           | <input type="checkbox"/> Anemia                      | Date _____  | <input type="checkbox"/> Hearing impairment            |
| <input type="checkbox"/> Heart surgery/procedures         | <input type="checkbox"/> Blood disorders             | Radiation: _____  | <input type="checkbox"/> TMJ (jaw joint) concerns      |
| <input type="checkbox"/> Heart attack                     | <input type="checkbox"/> Hepatitis A/B/C             | Chemotherapy: _____                                     | <input type="checkbox"/> Physical impairment           |
| <input type="checkbox"/> Stroke/T.I.A                     | <input type="checkbox"/> Hemophilia                  | Surgery _____   | <input type="checkbox"/> Arthritis                     |
| <input type="checkbox"/> Heart murmur                     | <input type="checkbox"/> Excessive bleeding/bruising | <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Osteoporosis                  |
| <input type="checkbox"/> Mitral valve prolapse            | <input type="checkbox"/> Immunodeficiencies          | <input type="checkbox"/> Respiratory conditions         | <input type="checkbox"/> Long-term Actonel/Fosomax use |
| <input type="checkbox"/> Congenital heart disease         | <input type="checkbox"/> Eating disorder             | <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Epilepsy/seizures             |
| <input type="checkbox"/> Infective Endocarditis           | <input type="checkbox"/> Lupus                       | <input type="checkbox"/> Snoring/sleep apnea            | <input type="checkbox"/> Cognitive impairment          |
| <input type="checkbox"/> Pacemaker                        | <input type="checkbox"/> Thyroid disease             | <input type="checkbox"/> Dizziness/fainting             | <input type="checkbox"/> Depression                    |
| <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Kidney disease              | <input type="checkbox"/> HPV                            | <input type="checkbox"/> Anxiety                       |
| <input type="checkbox"/> Low blood pressure               | <input type="checkbox"/> Liver disease               | <input type="checkbox"/> Herpes/cold sores              | <input type="checkbox"/> Mental health issues          |
| <input type="checkbox"/> General Anesthetic complications | <input type="checkbox"/> Joint replacement           | <input type="checkbox"/> Ulcers/acid reflux             | <input type="checkbox"/> Drug/alcohol dependency       |
| <input type="checkbox"/> Diabetes: Type I or II           | joint _____  | <input type="checkbox"/> Intestinal/stomach problems    | <input type="checkbox"/> Tobacco Use                   |
| <input type="checkbox"/> Hypoglycemia                     | date _____   | <input type="checkbox"/> Above average weight gain/loss | <input type="checkbox"/> Other _____                   |

Do you have any allergies or sensitivities to: Medication: \_\_\_\_\_  
 Food: \_\_\_\_\_  
 Environment: \_\_\_\_\_

Are you pregnant? No  Possibly  Yes  If so, how many weeks: \_\_\_\_\_

Have you had any surgery in the past or coming up in the near future: No  Yes

Explain: \_\_\_\_\_

Is there anything else to report about your health not listed above? \_\_\_\_\_

List ALL current medications including prescription, herbal/naturopathic or over the counter MEDICATIONS:

**Information for our Patients**

At Dawson Dental Centres, all professional dental services are performed by licensed members of the Royal College of Dental Surgeons ("Dental Professionals"), and all institutional health care services are performed independently by Dawson Dental Centres Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Dawson Dental Centres and Dawson Dental Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Dawson Dental Health Services.

**Privacy Act and Consent to Treatment**

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Dawson Dental Centres and Dawson Dental Health Services; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Dawson Dental Centres to provide the services you are requesting.

**Acknowledgment regarding Information Provided**

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical - dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Dawson Dental Centres and Dawson Dental Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Dawson Dental Centres and Dawson Dental Health Services in accordance with their current practices, which may involve transfer and retention offsite. I, the undersigned, acknowledge that the Dawson Dental Centres and Dawson Dental Health Services are relying upon the information which I have provided being accurate and complete.

Patient (Please Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient  Parent  Guardian  Patient  Parent  Guardian

Dentist (Please Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_