BITE
Dentalworks

Dr. Andrew Hoe

PATIENT REGISTRATION AND MEDICAL HISTORY QUESTIONNAIRE

PATIENT: Mr. / Miss / Mrs. / Ms. / Dr.

FIRST NAME: _____

LAST NAME: _____

GENDER: _____

DATE F BIRTH (D/M/Y) ____/____/____

ADDRESS _____

POSTAL CODE _____

HOME PHONE _____

CELL PHONE _____

OCCUPATION _____

BUSINESS PHONE _____

EMAIL _____

HEALTH CARE NUMBER _____

PERSON RESPONSBILE FOR ACCOUNT _____

RELATIONSHIP TO PATIENT _____

NAME _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

_____

DATE OF BIRTH (D/M/Y/) ____/____/____

EMPLOYER _____

IN CASE OF EMERGENCY , WE SHOULD NOTIFY:

NAME _____

RELATIONSHIP _____

DAYTIME PHONE _____

CELL PHONE _____

WHO MAY WE THANK FOR REFERRING YOU: _____

The following information is required to enable us to provide you with the highest standard of care. All information is kept confidential. The doctor will review the questions and explain any that you do not understand. Please complete the entire form. If you need assistance, please notify one of our front desk team members and help will be provided.

HEIGHT _____ WEIGHT _____

Are you being treated for any medical condition at the present or have you been treated within the past year?

Yes No Not sure/Maybe

If yes, why and who treated you? _____

_____

When was your last medical checkup? _____

Has there been any change in your general health in the past year? Yes No Not sure/Maybe

If yes, please explain. _____

_____

Have you had any serious illnesses? Yes No Not sure/Maybe

If yes, please explain. _____

_____

Have you ever been hospitalized for any illness or operations? Yes No Not sure/Maybe

If yes, please explain. _____

_____

Have you been hospitalized within the last 2 years? Yes No Not sure/Maybe

Have you been out of Canada within the last 2 years? Yes No Not sure/Maybe

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes No Not sure/Maybe

If yes, please list with dosage and frequency _____

_____

Do you use any cannabis products? Yes No Not sure/Maybe

If yes, please list with dosage and frequency _____

_____

Do you smoke/vape or chew tobacco products? Yes No Not sure/Maybe

If yes, how much? _____

Do you have any allergies including medications, latex/rubber products, eggs/food etc? Yes No Not sure/Maybe

If yes, please list _____

Have you ever had an unexpected or adverse reaction to any medications, anesthetics or injections? Yes No Not sure/Maybe

If yes, please list _____

Do you have or have you ever had asthma? Yes No Not sure/Maybe

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (e.g. infective endocarditis), or a heart condition from birth (e.g. congenital heart disease)? Yes No Not sure/Maybe

Do you have a prosthetic or artificial joint? Yes No Not sure/Maybe

If yes, what year and what joint? _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiation therapy, chemotherapy? Yes No Not sure/Maybe

Have you ever had hepatitis, jaundice or liver disease? Yes No Not sure/Maybe

Are you taking any anticoagulation (blood thinner) medications? Yes No Not sure/Maybe

If so, what and when was your most recent INR? _____

Do you have a bleeding problem or bleeding disorder? Yes No Not sure/Maybe

Do you have or have you ever had any of the following? Please circle which apply:

Chest pain/angina	Bone, muscle or joint disorders	Thyroid disease	Osteoporosis medications (e.g. Fosamax, Actonel)
Rheumatic fever	Lung disease	Anxiety/Depression	Diet pill therapy
Pacemaker	Diabetes	Heart murmer	High blood pressure
Corticosteroid therapy	Kidney disease	Cancer	Fainting spells
Seizure Disorder (epilepsy)	Stroke	Arthiritis	Sleep Apnea/CPAP machine
Heart attack	Tuberculosis	Drug/alcohol dependency	Shortness of breath
	Stomach ulcers		

Can you easily walk up a flight of stairs? Yes No

Are there any conditions or diseases not listed above that you have or have had? Yes No Not sure/Maybe

If yes, please list _____

Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease?)

Yes No Not sure/Maybe

If yes, please list _____

Are you nervous during dental treatment? Yes No Not sure/Maybe

For women only: Are you pregnant or breast feeding? Yes No Not sure/Maybe

If pregnant, what is the expected delivery date? _____

Consent for the following: I hereby give consent for an examination, any necessary x-rays, and/or any other necessary diagnostic procedures. I have read and understand the above information and have answered all questions to the best of my knowledge.

Signature _____ Date _____

Signature _____ Date _____