BRITANNIA DENTAL CENTRE

DR. N. PARSA

WELCOME

NAME: Mr./ Mrs./ Miss/ Ms/ Dr. ______________________________

DATE OF BIRTH: Day/Month/Year ______________________________
HOME ADDRESS: ______________________________
____

PHONE NUMBER: HOME- ______________ WORK- ______________

OCCUPATION: ______________________________
EMERGENCY CONTACT NUMBER: ______________________________
REFERRED TO OUR OFFICE BY? ______________________________
DENTAL INSURANCE COVERAGE:
NAME OF INSURANCE COMPANY: ______________________________
NAME OF POLICY HOLDER AND DATE OF BIRTH: ______________________________
PLAN # ______________ I.D. # ______________

The following information is required to help us provide you with the best possible dental care. All information is strictly private. Please fill the entire form.

Are you being treated for any medical condition at the present or have you been treated within the past year? If so why? **YES NO** ______________________________

When was your last medical checkup? ______________________________

Has there been any change in your general health in the last year? If yes, please explain.
YES NO ______________________________

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. **YES NO** ______________________________

Do you have any allergies? If you answered yes, please list using the categories provided. **YES NO**
MEDICATIONS: ______________________________
LATEX/RUBBER PRODUCTS: ______________________________
OTHER e.g. HAYFEVER, FOODS: ______________________________

Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
YES NO ____

Do you have or have you ever had asthma? **YES NO**

Do you have or have you ever had any heart or blood pressure problems? **YES NO**

Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever? **YES NO**

Do you have a prosthetic or artificial joint? **YES NO**

Have you ever been advised by your doctor to take antibiotics before dental treatment?
YES NO

Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? **YES NO**

Have you ever had hepatitis, jaundice or liver disease? **YES NO**

Do you have a bleeding problem or bleeding disorder? **YES NO**

Have you ever been hospitalized for any illness or operation? If yes, please explain.
YES NO

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Do you have or have you ever had any of the following?

___Chest pain, angina	___Shortness of breath	___Pacemaker	___Steroid therapy
___Heart attack	___Prosthetic heart Valve	___Lung disease	___Diabetes
___Stroke		___Tuberculosis	___Stomach Ulcers
___Cancer	___Arthritis	___Kidney Disease	
___Diet pill therapy	___Thyroid Disease	___Drug/Alcohol dependency	
___Seizures(epilepsy)			

Are there any conditions or diseases not listed above that you have or have had? If so, what? **YES NO**

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Are there any diseases or medical problems that run in your family? **YES NO** ____________

Do you smoke or chew tobacco products? **YES NO**

Are you nervous during dental treatment? **YES NO**

FOR WOMEN ONLY: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date? **YES NO** ____

To the best of my knowledge, the above information is correct:

Patient/parent/guardian signature:___________________________

Date :___________________________