Dr. Rose Dhillon, DMD
Dr. Doug McDermid, DMD
Dr. Derek Milani DMD
Dr. Shauna Murray, DMD

120-40 Lakewood Boulevard
Winnipeg, MB R2J 2M6
204-257-6961

Medical History

FIRST NAME: _____
LAST NAME: _____
DATE OF BIRTH (DAY/MONTH/YEAR): / /
ADDRESS (HOME):
_____
POSTAL CODE:
Gender: ☐ male ☐ female ☐ other
Phone Number:
Email Address: _____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:
NAME: _____
RELATIONSHIP:

NAME OF FAMILY DOCTOR:
PHONE OR ADDRESS:

How did you find our office? (referral source)_____

Insurance Information

Insurance Company _____

Plan/Policy/Group #_____ ID/Certificate # _____

Name of Subscriber _____

Date of birth of subscriber _____

*Employer _____ (if the plan is covered through your workplace)

***To ensure that your medical history is accurate, please fill out in the entire form.**

1. When was your last medical checkup? _____
2. Do you have any of the following? :
   * Prosthetic heart valve or heart valve repair ☐ Yes ☐ No
   * History of heart infection (infective endocarditis) ☐ Yes ☐ No
   * Heart transplant ☐ Yes ☐ No
   * Congenital heart disease/defect (present from birth) ☐ Yes ☐ No
3. Have you had head or neck radiation? ☐ Yes ☐ No
   * Details: _____

4. Do you have or have you ever had any of the following medical conditions/symptoms?

☐ chest pain, angina/coronary artery disease
☐ high blood pressure
☐ low blood pressure
☐ atrial fibrillation
☐ pacemaker/implantable defibrillator
☐ congestive heart failure
☐ history of heart attack or stroke/TIA
☐ history of cardiac bypass surgery (CABG)
☐ bleeding disorder/taking blood thinners
☐ other cardiac disease, please specify: _____

☐ Asthma
☐ COPD
☐ Other respiratory disease, please specify:

_____

☐ Type I Diabetes
☐ Type II Diabetes
☐ current HbA1c: _____
☐ undergoing dialysis
☐ liver cirrhosis
☐ fatty liver
☐ history of hepatitis, please detail: _____
_____
☐ other liver disease, please specify: _____
_____

☐ History or currently taking Bisphosphonate/bone density pills or injections eg. Fosamax/Alendronate, Actonel/Risedronate, Aclasta/Zolendronate, Prolia/Denosumab
☐Dental Anxiety/phobia
☐ ADHD
☐ Dementia
☐ Cognitive impairment
☐ Anxiety
☐ Depression
☐ PTSD
☐ other, please specify:
_____

☐ steroid therapy
☐ immunosuppressant medications
☐auto-immune condition, please specify: _____
_____
☐ history of seizures
*When was your last seizure?
_____

☐ hepatitis
☐ HIV
☐Herpes
☐ other, please specify: _____
_____
☐ history of or current cancer
*Type of cancer _____
☐ history of chemo/immunotherapy
☐ arthritis

☐ substance abuse, please specify: _____
_____

5. Please provide details on any of the above conditions:
_____
_____
_____
_____

6. Current medications (please specify names or provide a medication list):
_____
_____

7. Allergies:
_____
_____

8. Previous medical procedures/surgeries/hospitalizations:
_____
_____

9. Alcohol/tobacco/drug use -information to be used for oral cancer screening purposes
* current alcohol use: _____ alcoholic beverages per day/week/month/year (circle one)
* current cigarette/vaping use: ____ cigarettes per day/week/month/year (circle one) for _____years
* current cannabis use (smoke, vape, edible, oil): ____grams per day/week/month/year (circle one)
* past alcohol/tobacco/drug use if significantly different than current use: _____
* current or past recreational drug use: _____

***FOR WOMEN ONLY**:*
* Pregnant? ☐ Yes ☐ No Expected delivery date: _____
* Are you breastfeeding? ☐ Yes ☐ No

Dental History

1. When was your last dental visit? _____
2. When was your last cleaning? _____
3. Did you have xrays taken within the last year? ☐ Yes ☐ No
4. How would you describe your dental health at present? ☐ Good ☐ Fair ☐ Poor
5. What are your present concerns today, if any? _____

☐ bleeding gums ☐ crooked teeth ☐ cosmetic ☐ loose teeth ☐ bad breath
☐ food trapping ☐ sensitive teeth ☐ toothache ☐ loose dentures ☐ missing teeth/spaces
☐ want whiter teeth ☐ other_____

6. Are you dissatisfied with the appearance of your teeth? ☐ Yes ☐ No
   If yes, please explain _____
7. Have you ever had complications after extractions? ☐ Yes ☐ No If yes, please explain;
   _____
8. Are you anxious during dental visits? ☐ Yes ☐ No _____
9. Do you think you might like to have your dental treatment done with sedation? ☐ Yes ☐ No

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. I agree to the privacy policy of this office and consent to the electronic sharing of information with my insurance company for the purposes of processing insurance claims and the determination of benefits. Unless other arrangements are made payment is due at each visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist. I authorize the dentist to treat me and I assume full responsibility of the fees. I am aware that two business days notice is required to change or cancel an appointment without charge.

I understand that an electronic copy of my signature and the information I have provided will be created. This electronic copy will serve as a genuine copy of the original for medico-legal purposes.

PATIENT (PARENT/GUARDIAN) SIGNATURE	DATE
STAFF SIGNATURE	DATE