Millcroft Dental Care

for Family and Cosmetic Dentistry

(Please be advised all information is private, confidential and for our records only)

Welcome to our dental practice **(Please turn over)**

Patient Information:

Name: □ Mr. □ Ms. _____
(First Name) (Last Name)

Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: Day: _____ Month: _____ Year: _____ Age: _____

Phone Number: Home: _____ Cell: _____ Work _____ Ext: _____

Email: _____

Preferred Method of Contact: (Please circle one) Text Email Call Cell Call Home

Insurance Information:

Insurance Info: Policy# _____ ID# _____

Company Name: _____ Policy Holder: _____

Policy Holder Date of Birth: _____

Medical Contact Information:

Family Physician: _____ Phone: _____ City: _____

Address: _____ Postal Code: _____

Specialist: _____ Phone: _____

Emergency Contact Information:

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Today's Visit:

Reason for this appointment: _____

Do you have dental insurance? Yes □ No □

How did you hear about us? (Please Circle) Flyer Drive/Walk by Online Friend

Whom may we thank for referring you to this office: _____

Medical History: Pre-Medicate:

Date of your last physical exam: _____ Date of last visit with your doctor: _____
Would you consider yourself to be in good health? _____ Yes □ No □
Have you been hospitalized in the past two years? _____ Yes □ No □
(If yes, why?) _____
Have you had any surgeries? Date and reason: _____
Do you smoke? If yes how much? _____ Yes □ No □
Are you taking any medications? _____ Yes □ No □

Please list: _____

WOMEN ONLY: Are you pregnant? Yes □ No □ Due Date: _____ Are you taking birth control? Yes □ No □

Medical Conditions:

Please indicate any conditions you currently have or have had in the past:

□ Cancer
□ Chemotherapy/Radiation
□ High Blood Pressure
□ Low Blood Pressure
□ Diabetes Type 1
□ Diabetes Type 2
□ Heart Palpitations
□ Congestive Heart Failure
□ Artificial Heart Valve
□ Mitral Valve Prolapse
□ Heart Attack/Cardiac Arrest
□ Congestive Heart Lesion
□ Mental/ Nervous Disorders
□ Heart Surgery
□ Heart Murmur
□ Heart Problems
□ Chest Pain
□ Angina Pectoris
□ Osteoporosis
□ Arthritis / Gout
□ Thyroid Disease
□ Artificial Joints
□ Cosmetic Surgery
□ Glaucoma
□ Epilepsy/ Seizures
□ Tattoos
□ Lung Disease
□ Abnormal Bleeding
□ Herpes
□ Cold Sores
□ Fever Blisters
□ Liver Disease (Hepatitis A,B,C)
□ Head/ Neck Injuries
□ Fainting/ Dizziness
□ Sinus Trouble
□ Headaches
□ Frequent Cough
□ Drug/ Alcohol Addiction, have you received treatment? _____
□ Scarlet Fever
□ Rheumatic Fever
□ Malignant Hyperthermia
□ Tuberculosis
□ Crohn's Disease
□ Ulcers/ Stomach Concerns
□ Blood Disorder
□ ADHD/ ADD
□ Autism
□ Stroke
□ STI's
□ AIDS (HIV)
□ Anemia
□ Kidney Disease
□ Lung Disease
□ Emphysema
□ Hernia
□ Pacemaker
□ Asthma
□ Bronchitis
□ Joint Pain

Are you taking any blood thinners? (Warfarin/ Coumadin/ Plavix/ Aspirin/ Other): _____

Are there any other medical concerns we should be aware of? _____

Allergies and Reactions:

Please indicate which medications or materials you are allergic to, or have had a reaction to in the past:

□ Aspirin
□ Codeine
□ Percocet/ Oxycocet
□ Tylenol #1, #2, #3
□ Ibuprofen (Advil)
□ Naproxen
□ Toradol
□ Metal
□ Demerol
□ Percodan
□ Penicillin
□ Amoxicillin
□ Ampicillin
□ Erythromycin
□ Clindamycin
□ Tetracycline
□ Rocamycine
□ Cephalexin
□ Sulfa Drugs
□ Latex
□ Local Anesthetic (Freezing)
□ Nitrous Oxide
□ Valium
□ Chlorhexidine (Peridex)
□ Cephalosporin (Keflex)

Please list any food allergies: _____

Please list any other drug or material allergies not listed above: _____

NOTES: _____

_____

Patient Signature: _____ Date: _____

Dentist Signature: _____