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
- ☐ 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
- ☐ Drug/ Alcohol Addiction, have you received treatment? _____

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: _____