

Barrie Dental Specialists

34 Quarry Ridge Rd, Suite 200 • Barrie, ON L4M-7G1

(705)722-1104

BDS Medical & Dental History Form

Patient Name: _____
Last First MI Preferred Name

I would like to spend some time with you to record your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Name of referring dentist and dental office *

Why have you been referred to Barrie Dental Specialists? *

Would you consider yourself to be in; *

Excellent health Good health Fair health Poor health

Within the past year, have there been any changes in your general health? If yes, please elaborate. *

Yes No Not Sure/Maybe

What is the date (or approximate date) of your last medical exam? *

Your Primary Care Physician's Name, Address and Phone #:

Health Card Number #

Nearest Pharmacy Name, Address and Phone #

Do you have or have you ever had Asthma? *

Yes No Not Sure/Maybe

Do you have or have you ever had any heart or blood pressure problems? *

Yes No Not Sure/Maybe

What is your Blood Pressure (Typically)? _____

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or heart transplant? *

Yes No Not Sure/Maybe

Do you have a prosthetic or artificial joint? *

Yes No Not Sure/Maybe

Do you require pre-medication prior to dental treatment? Yes No

Type of Pre-medication:

Do you have or have you ever had any of the following? Please check.

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest pain/Angina | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke, TIA |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hepatitis A, B,C | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Drug/alcohol/ cannabis use or dependency | <input type="checkbox"/> Seizures (epilepsy) |
| <input type="checkbox"/> kidney disease | <input type="checkbox"/> Osteoporosis medications | |

Details:

If you have Diabetes, when was your most recent A1C Test completed? _____

What was your most recent A1C Test result? _____

What is your typical A1C Test result? _____

Are there any conditions or diseases not listed previously that you have or have had? If yes, please explain *

- Yes No Not sure/Maybe

Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? *

- Yes No Not Sure/Maybe

Have you ever been hospitalized for any illness or operations? if yes, please explain. * Yes No

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

Yes No Not sure/Maybe

Are you nervous during dental treatment? *

Yes No Not sure/Maybe

Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? *

Yes No Not sure/Maybe

Expected delivery date: _____

What is important to you about your oral health? *

If you could change anything about your mouth, teeth, or smile, what would it be? *

Is there anything else we should know regarding your past dental history, including any specific concerns? *

Do you identify as a patient with a disability? If yes, how may we best assist you in our dental practice? * Yes No

- * To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

- * I hereby certify that I have been provided with and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

- * I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

- * I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

- * I understand that Barrie Dental Specialists is a fee for service dental specialty practice and I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

* I understand that Barrie Dental Specialists may use AI tools to assist in documentation and communication. No diagnostic decisions will be made by AI. All care is supervised by a licensed clinician.

Response Date: _____