THE DMD EMERGENCY TREATMENT SYSTEM 2

Please complete the information on both sides before signing.

NAME

Date _____ Dentist _____

The patient is an: ADULT ☐ CHILD ☐ ADULT UNDER GUARDIANSHIP ☐

Dr. ☐ Mr. ☐ Mrs. ☐ Ms.. ☐ Miss ☐

Name of Guardian: _____

Name: (last) (first) (initial)

Address: (street) (apt.#) (city) (province) (postal code)

Date of Birth: M D Y Age: _____ Home Phone: ( ) _____

Driver's License No. _____ Office Phone: ( ) _____
(If required by office)

Do you have a regular dentist? Yes ☐ No ☐ Date of your last dental visit? _____

Name of Dentist: _____ Phone: ( ) _____

Family Physician: _____ Phone: ( ) _____

Medical Specialist: _____ Phone: ( ) _____
(if presently under care)

In case of emergency, please contact: _____ Phone: ( ) _____

Closest family relative: _____ Phone: ( ) _____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions about my medical history. I authorize the dentist to perform procedures and treatment as may be necessary and understand this treatment is for my immediate problem, and should not be regarded as a complete examination with resulting treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of these dental services is mine, and I assume responsibility for fees associated with these services.

X _____ (signature)

PATIENT ☐ PARENT ☐ GUARDIAN ☐

_____ (print name of guardian)

FORM: DMDET2C Rev. 3

HEALTH HISTORY

	YES	NO
1. Have you been under the care of a Medical Doctor during the past two years, or have you been hospitalized in the last two years? If yes, please specify? _____	☐	☐
Physician: _____ Phone: _____		
2. When was your last complete physical examination? _____		
3. Have you recently, or are you presently, taking any **PRESCRIPTION OR NON-PRESCRIPTION** drugs incl. herbal remedies? 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	☐	☐
4. Have you ever reacted adversely to any of the following? (Please circle.) ANTIBIOTICS - Penicillin, Sulfonamide, other antibiotics, ASPIRIN, BARBITURATES (sleeping pills), CODEINE, DARVON, LOCAL ANAESTHETIC (freezing), NITROUS OXIDE, or been advised against taking any specific type of medication? If so, please list: _____	☐	☐
5. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? _____	☐	☐
6. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: _____	☐	☐
7. Has any family member had diabetes? _____	☐	☐
8. Do you bleed **EXCESSIVELY** from a cut or injury, or bruise easily? _____	☐	☐
9. Do your ankles, feet or hands swell? _____	☐	☐
10. Has your weight, appetite or energy level changed dramatically recently, or do you follow a special diet? _____	☐	☐
11. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
12. Have you tested HIV positive? _____	☐	☐
13. Do you have **FREQUENT SEVERE** headaches, earaches, ear/throat infections? _____	☐	☐
14. Have you ever had any injury or surgery to your face, jaws or jaw joints? _____	☐	☐
15. Do you wear eyeglasses or contact lenses, or have you had any hearing difficulties? _____	☐	☐
16. Do you smoke, use other forms of tobacco, or are you wearing the transdermal nicotine patch?	☐	☐
17. Are you alcohol and/or drug dependent? _____	☐	☐
18. Have you been advised to take antibiotics before a dental appointment? _____	☐	☐
19. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:		
(Please circle.) A.I.D.S. Anemia Angina Pectoris Arthritis/rheumatism Artificial heart valve Artificial joints (hip,knee) Blood disorders Bronchitis Cancer Circulation problems Congenital heart lesions Cortisone/steroid Diabetes Emphysema Epilepsy or seizures Fainting or dizzy spells Glandular disorders Glaucoma Head/neck injuries Heart disease/attack Heart murmur Heart pacemaker Heart rhythm disorder Heart surgery Hepatitis A B C ___ Herpes High/low blood pressure Hodgkins disease Hyper (hypo) Glycemia Hypertension Jaundice Kidney/liver disease Lung disease Malignant Hyperthermia Mental/nervous disorder Mitral valve prolapse Organ transplant/medical implant Psychiatric treatment Radiation treatment/chemotherapy Rheumatic/Scarlet fever Sickle Cell disease Sinus trouble Stomach/intestinal problems Stroke Thyroid disease Tuberculosis Ulcers Venereal disease Other _____		
20. Has the Child Patient recently had any of the following: (indicate approximate date) Chicken Pox _____ Mumps _____ Measles _____ Strep throat _____ Tonsillitis _____		
21. Do you currently have, or have you had in the past, any disease, condition or problem not listed?	☐	☐
22. Is there anything else about your health we should be made aware of? _____	☐	☐
23. Do you wish to speak to the Doctor privately about any problem or medical condition? _____	☐	☐
24. **WOMEN ONLY:** Are you pregnant or suspect you may be? _____ If yes, what month? _____ Are you taking any birth control pills? _____ Are you breast feeding? _____		