Dr. Michele Pakozdi

Suite 103 - 460 Main Street East, Hamilton, Ontario L8N 1K4

Patient's Name _____
Surname First Middle Initial

Date of Birth _____
Month Day Year

Address _____ Apt.# _____

City _____ Postal Code _____

Telephone: Home: _____ Business: _____ Ext.# _____

Occupation/Employer: _____

Who referred you to our office? _____

Do you have "Dental Insurance"? Yes ☐ No ☐ Date of Birth: _____

Name of Insurance Company: _____ Policy #: _____

Policy Holder: _____ Division #: _____

Relationship of patient to policy holder: _____ I.D or Certification #: _____

Secondary Coverage:

Policy Holder: _____ Carrier: _____ Birth Date: _____

Policy #: _____ Certificate #: _____

Emergency Contact: Name: _____ Relationship: _____

Phone Number: _____

Physician's Name & Phone Number: _____

Do you have any medical condition(s) requiring antibiotics before your dental treatment? Yes ☐ No ☐

If yes, what is the condition? _____

When was your last medical check up? _____

Have there been any changes in your general health in the past year? Yes ☐ No ☐

If yes, please explain: _____

Please list all current medications including prescription and non-prescription drugs and herbal supplements, especially St. John's Wort, flax seed, flax seed oil, chinese mushroom:

_____

_____

_____

Do you have any allergies? Yes ☐ No ☐ If you answered yes, please list using the categories below:

a) medications: _____

b) latex/rubber products: _____

c) other (ex. hayfever, foods): _____

Have you ever had an unusual or adverse reaction to any medications or injections? Yes ☐ No ☐

If yes, please explain: _____

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 a heart transplant? Yes ☐ No ☐

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiation therapy, chemotherapy? Yes ☐ No ☐

Have you ever had a joint replacement? Yes ☐ No ☐

Have you ever been hospitalized for any illnesses or operations? Yes ☐ No ☐

If yes, please explain: _____

Do you have or have you ever had any of the following? Please check if yes:

☐ Heart problems	☐ Heart attack	☐ Bypass surgery	☐ Rheumatic fever
☐ Cancer	☐ Kidney disease	☐ Asthma/Bronchitis	☐ Blood disorders
☐ Stomach ulcers	☐ Head/Neck injuries	☐ Sinusitis	☐ Osteoporosis medications (ex. Fosamax, Actonel)
☐ High blood pressure	☐ Chest pain, angina	☐ Stroke	☐ Mitral valve prolapse
☐ Thyroid disease	☐ Lung disease	☐ Hepatitis	☐ Bleeding problems
☐ Arthritis	☐ Car accident injuries	☐ Steroid therapy	☐ Drug/Alcohol dependency
☐ Low blood pressure	☐ Pacemaker	☐ Shortness of breath	☐ Heart murmur
☐ Liver disease	☐ Tuberculosis	☐ Diabetes	☐ Anemia
☐ Rheumatism	☐ Migraines	☐ Osteoporosis	☐ Epilepsy (seizures)

Do you smoke or chew tobacco products? Yes ☐ No ☐

Is there any other information we should know about your health? _____

For women only: Are you breastfeeding or pregnant? Yes ☐ No ☐ Not Sure/ Maybe ☐

If pregnant, what is the expected delivery date? _____

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 assume responsibility for fees associated with these services and authorize release of any information regarding my diagnosis or treatment to my dentist or my physician.

_____ Date: _____

(Signature) Patient ☐ Parent ☐ Guardian ☐

_____ Date: _____

(Print Name of Guardian)

Signature of Dentist: _____ Date: _____

Signature: _____ Date: _____

Parent's Signature (for children under 18 years of age)

Signature of Dentist: _____ Date: _____

Signature: _____ Date: _____

Parent's Signature (for children under 18 years of age)

Signature of Dentist: _____ Date: _____