Emergency Medical History Form

The staff at Sapperton Dental would like to welcome you to their practice.

To assist us in providing you with the best possible treatment and standard of care, we ask that you complete this confidential medical history questionnaire.

Personal Details:

Name: ____Date of Birth: ________________ Age: __________

Address: __________________________________City________________________Postal Code: _______________

Phone Home#______________ Cell #_______________ Email:____

Insurance Company_____________________________ Policy#____________________ ID#_________________

Policy Holder's name: ________________________________Date of Birth of Policy Holder: _______________________

Dental History: Are you having any discomfort at this time? If yes please specify:______________________________

Have you been under the regular care of a dentist?____

How long since your last dental visit?____

Medical Information: Medical Doctor/Contact phone #:____

Are you presently under the care of a medical doctor: If yes please specify :_______________________________________

Are you presently taking any medication, including non-prescription, herbal supplements and/or vitamins:__________________

Do you have any **allergies** or had any reaction to (medications, anaesthetics, metals, latex, antibiotics etc.):_______________

Do you have or have you had any of the following:

High Blood Pressure	Y / N	Anemia	Y / N	Sinus Problem	Y / N	Low Blood Pressure	Y / N
Arthritis	Y / N	Cancer/Chemo	Y / N	Tuberculosis	Y / N	Headaches	Y / N
Thyroid Problems	Y / N	Diabetes	Y / N	Stroke	Y / N	Heart Disease	Y / N
Head/Neck Injuries	Y / N	Hepatitis	Y / N	Chest Pain	Y / N	Blood Disorders	Y / N
Asthma	Y / N	Liver Disease	Y / N	Epilepsy	Y / N	Rheumatic Fever	Y / N
Heart Murmur/Problems	Y / N	Ulcer	Y / N	Emphysema	Y / N	Glaucoma	Y / N

Office Policy :Your appointment time will be reserved especially for you. If you are unable to keep the appointment we require two business days notice, otherwise, it may be necessary to charge for the time lost. __________Please initial

The dentist shall obtain my verbal consent before performing any dental procedure. I understand that I am ultimately responsible for the total fees associated with the treatment performed this is including the fees not covered by my insurance policy _______Please initial.

Date:__________________Patient Signature:____

Phone: (604) 544 0894 Fax: (604) 544 0895 www.sappertondental.com
info@sappertondental.com 105-301 East Columbia Street New Westminster BC V3L 3W5