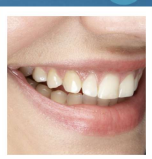
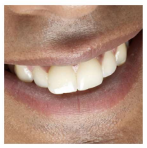
Anchor Health Services Anchor Dental Group
276 2nd Ave N.E. , Suite 3
Swift Current, SK S9H2C8

(306)778-9100
anchordental@sasktel.net
www.anchordentalgroup.com





Medical History Form

Chart #. _____
FOR OFFICE USE ONLY

Patient Name:* _____ * _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender:* ◯ Male ◯ Female Family Status:* ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* _____ Prev. Visit: _____ Email Address: _____

Phone:* _____ _____ _____ _____ Best time to call: _____
Home Work Ext Mobile

Address:* _____ _____
* _____ * _____ * _____
City PV Postal Code

Guardian Name (if applicable):

_____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that is conscientious of your overall health and well-being.

Name of your physician and phone number:

_____

Last complete physical examination?

_____

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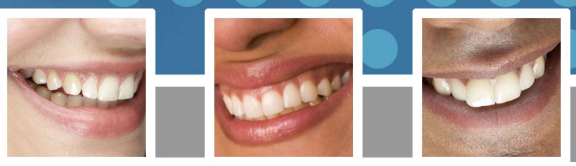

Please explain any medical treament or hospitalizations within the past two years?

Please list any other past operations, or upcoming surgery(s) / procedures you will be having.

Have you recently, or are you presently, taking any PRESCRIPTION or NON-PRESCRIPTION drugs? Please list the name and dosage:

Please list any medications you may have been advised against taking:

Have you ever reacted adversly to any of the following?

- ☐ Penicillin
- ☐ Keflex
- ☐ Dalacin
- ☐ Sulfa
- ☐ Aspirin
- ☐ Valium
- ☐ Codeine
- ☐ Narcotics
- ☐ Local Anesthetic (freezing)

Do you take antibiotic premedication prior to your dental visits? If yes, please explain.

Do you have any of the following?

- ☐ Asthma
- ☐ Hay Fever
- ☐ Food Allergies
- ☐ Metal Allergy
- ☐ Latex Allergy
- ☐ Skin Rashes
- ☐ Hives
- ☐ Other allergic reactions

Describe any headache, nausea, swelling, shortness of breath, or chest constriction you may have had from an allergic reaction?

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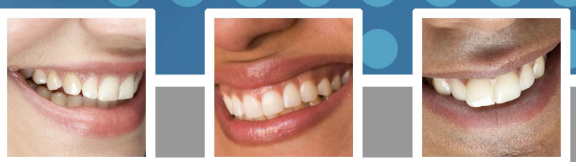

Indicate which of the following conditions or treatments you have or have had. By checking the box it will indicate a "YES" reponse, leaving blank will indicate a "NO" response.

☐ *Pre-Medication	☐ *See Patient Notes	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Iodine	☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin
☐ Allergy - Sulfa	☐ Allergy-Erythromycin	☐ Allergy-Local Anesth	☐ Anemia
☐ Anxiety or Depresion	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Auto-Immune Disease	☐ Bisphosphonates	☐ Blood Disorder	☐ Cancer
☐ Contraceptive Use	☐ Cortisone / Steroid	☐ Diabetes	☐ Dizziness/Fainting
☐ Emphysema	☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Excessive Bruising
☐ Fibromyalgia	☐ Gastro-Intestinal	☐ Glaucoma	☐ Hard To Freeze
☐ Hay Fever	☐ Head / Neck Injury	☐ Hearing Disabled	☐ Heart Attack/Stroke
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis B	☐ Hepatitis C
☐ High Blood Pressure	☐ High Cholesterol	☐ HIV+ (AIDS)	☐ Jaundice
☐ Kidney Disease	☐ Liver Disease	☐ Low Blood Pressure	☐ Mental Disorders
☐ Multiple Sclerosis	☐ Nervous Disorders	☐ Osteoporosis	☐ Pacemaker/Stents
☐ Radiation/Chemo	☐ Respiratory Problems	☐ Sinus Problems	☐ Skin Rash/Hives
☐ STD's / STI's	☐ Stomach Problems	☐ Thyroid Condition	☐ TMJ
☐ Tuberculosis	☐ Tumors/Growths	☐ Ulcers	☐ Wheelchair

Is there family history of any of the above? Please list.

If any conditions or alerts selected above need further clarification, please describe below:

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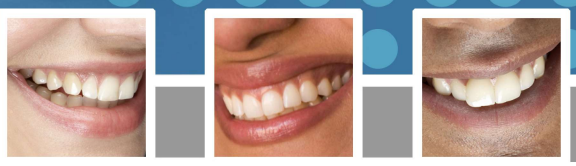

WOMEN ONLY: Please mark if any of the following apply

- ☐ Pregnant
- ☐ Suspect Pregnancy
- ☐ Nursing
- ☐ Taking Birth Control

Please mark if any of the following apply to you:

- ☐ Excessive Bleeding from a cut / injury or bruise easily
- ☐ Thirtsy most of the time or urinate more than 6 times per day
- ☐ Ankle, hands, or feet swell
- ☐ Dramatic change in weight, appetite or energy level recently
- ☐ Experience shortness of breath with stairs or walking
- ☐ Smoke or use any other forms of tobacco
- ☐ Alcohol or drug dependant
- ☐ Have frequent severe headaches, earaches, ear/ throat infections
- ☐ Had injury or surgery to your face or jaws

Please explain if you are taking or have ever taken BISPHOSPHONATE drugs such as Fosomax, Skelid, Actonel (for osteoporosis) or Aredia, Zameta, or Didronel (for cancer treatments)

Do you currently have, or have you had in the past, any disease, condition or problem not listed above?

Is there anything else about your health we should be made aware of?

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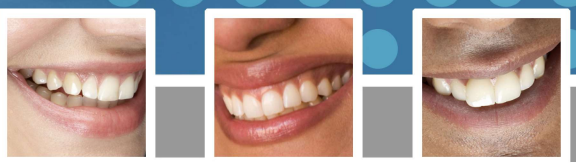

Authorization

I hereby certify that I have read 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.

* ☐ 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.

Signature of patient, parent, or guardian & witness:

If not self please state name and relationship:

Response Date: