

Patient Information

Patient Name: _____ Date of Birth: _____
Last First Preferred dd/mm/yyyy

Email: _____ Mobile# _____ Home# _____

Gender*: _____ Pronoun (Optional): _____

Address: _____
Apartment# Street City Postal Code

Emergency Contact Name: _____ Phone# _____ Relationship _____

**While our clinic recognizes a number of sexes/genders, many insurance companies and legal entities do not. Please understand that the legal name and gender listed on your insurance must be used on documents pertaining to insurance and billing. If your preferred name and pronouns are different from these, please let us know.*

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you currently being treated (or within the past year) for any medical? If yes, please explain.

YES NO NOT SURE/MAYBE

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain.

YES NO NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them.

YES NO NOT SURE/MAYBE

5. Do you have any allergies including allergy to medication and latex/rubber products? If yes, please list them.

YES NO NOT SURE/MAYBE

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

YES NO NOT SURE/MAYBE

7. Do you have or have you ever had asthma or shortness of breath?

YES NO NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems or chest pain?

YES NO NOT SURE/MAYBE

9. 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 NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? YES NO NOT SURE/MAYBE

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

YES NO NOT SURE/MAYBE

12. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.

YES NO NOT SURE/MAYBE

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

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Osteoporosis Medications (e.g. Fosamax, Actonel)
<input type="checkbox"/> Stroke, TIA	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Seizures (epilepsy)	<input type="checkbox"/> Drug/alcohol/cannabis use or dependency
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Mitral valve prolapse	<input type="checkbox"/> Kidney disease	
<input type="checkbox"/> Steroid therapy	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Jaundice/Liver disease	

14. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain

YES NO NOT SURE/MAYBE

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

YES NO NOT SURE/MAYBE

16. Do you smoke or chew tobacco products?

YES NO NOT SURE/MAYBE

17. Are you nervous during dental treatment?

YES NO NOT SURE/MAYBE

18. Are you breastfeeding or pregnant? If pregnant, what is the delivery date?

YES NO NOT SURE/MAYBE

19. Do you identify as a patient with a disability? If yes, please explain.

YES NO NOT SURE/MAYBE

20. Do you have any specific dental concerns you would like the doctor to address today? If yes, please explain.

YES NO NOT SURE/MAYBE

PATIENT ACKNOWLEDGEMENT AND CONSENT

I, the undersigned, certify that all above medical and dental information is true and I have not omitted any pertinent information.

I hereby consent to the performing of all dental and surgical treatments deemed necessary or advisable, including the use of local anaesthetic.

I acknowledge that I will assume full responsibility for the payment of all fees associated with these procedures. I acknowledge that my insurance plan may not cover all services provided, but that I will be responsible for the full payment of all fees. If my account has an outstanding balance, I authorize Dr. Kevin Russelo and Associates to charge such balance to my credit card account on file. I authorize the release, to my insuring company plan administrator, of the information contained in any claims submitted electronically.

Signature _____ Date: _____ Relationship to Patient: _____