DR. SAL ALCAIRE + ASSOCIATES

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 in 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 condition? 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? If yes, please list them or provide a medications list.
☐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.

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

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 person 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. Sal Alcaire 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: _____