VDSC
VANCOUVER DENTAL
SPECIALTY CLINIC

Confidential Medical & Dental History Form

Name: _____ _____ _____
Last First Preferred Name

Birth Date: _____ Phone: _____ _____ Email: _____
Day/Month/Year Home Mobile

Address: _____
City PV PC

What is your chief concern today?

_____
Occupation

Whom may we thank for referring you to our office?

_____

Within the past year, have there been any changes in your general health? ○ No ○ Yes

What is the date (or approximate date) of your last medical exam?

_____

Your Primary Care Physician's name, address, & phone number:

_____

When was your last dental visit? _____ WOMEN ONLY: Are you pregnant? ○ No ○ Yes
Month/Year

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you have Dental anxiety?

Please mark any of the following to indicate YES in response to the question:

_____

Please indicate if you have experienced or presently have any of the following:

- ☐ Allergy _____
- ☐ Arthritis or Rheumatism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Fainting/dizzy spells
- ☐ Hyper/hypo glycaemia
- ☐ Liver disease (Hepatitis/Jaundice)
- ☐ Mental or Nervous disorder
- ☐ AIDS/HIV
- ☐ Artificial joints or valves
- ☐ Cancer/radiotherapy/chemotherapy
- ☐ Eating disorders
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Lung disease/chest pains /Stroke
- ☐ Venereal/communicable disease
- ☐ Alcohol or chemical dependency
- ☐ Asthma
- ☐ Contraceptive use
- ☐ Epilepsy/seizures
- ☐ High/low blood pressure
- ☐ Excess bleeding
- ☐ Tuberculosis
- ☐ Stomach ulcers
- ☐ Sleep apnea

Do you have any other health issues, conditions, disease or allergies?

Are you currently taking any kind of medication? If YES, please specify:

Drug: _____ Reason: _____
Drug: _____ Reason: _____
Drug: _____ Reason: _____

Emergency Contact: _____

Is there any other family you would like to be seen? If so, please list below:

Names: _____ Relationship: _____

☐ I consent to having radiographic images taken for diagnostic purposes.

☐ 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.

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. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature: Date:

_____

Signature of patient, parent, or guardian: Relationship to Patient:

_____ _____