Welcome to Yonge Finch Dental Dr. Waji Khan & Associates, DENTAL SURGEONS

The personal information provided below will be protected and kept private at our office. All information will be used and disclosed responsibly according to the Privacy Act Standards set up and monitored by our office.

Mr.☐ Mrs.☐ Miss☐ Ms.☐ Dr.☐ **Given Name**:_____ **Marital Status**:_____

(Last) **Surname**:_____ **Pronunciation**:_____ **Prefer to be Called**:_____

Gender:_____ **Date of Birth**:_____ **Employer/Occupation**: _____

Address:

(street)_____***(Apt#)***_____***(Postal)***_____**.**

Home Phone: _(_____)_____ **Work Phone**: _(_____)_____ **Cell**: _(____)_____ **Email**: _____

Preferred Contact Method *(leave messages):* _____ **Are you likely available short notice for appointments:**_____

Best Time to Reach You? *(Please circle)* **Morning 8am-11am** **Afternoon 12pm-4pm** **Evening 5pm-8pm**

Who may we thank for referring you to this office?:_____.

Health Card Number(OHIP):_____**Family Physician:**_____**.**

In Case of Emergency Notify: _____ Relation:_____ Phone: _____.

IF PATIENT IS UNDER 18 YEARS OF AGE: Person responsible for account Parent:☐ Guardian:☐ Other:☐ _____.

Name: _____. Relation: _____. Phone Number: _____.

Address*: (only if address is different than provided) (street)* _____*Apt*_____*Postal Code*_____.

Medical History

1) Have you had a medical exam in the last year? _____.
2) Have you been hospitalized for a serious illness in the last 5 years (heart condition/joint replacement) or require extensive care?

   _____.
3) Do you use prescription drugs or non-prescription drugs regularly? Please Specify:

   _____.
4) Do you have any allergies or allergic conditions? (Hay Fever, Skin Rash, Food Allergies, Metal, Latex?)

   _____.
5) Have you ever experienced any unusual reaction to any of the following? Local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine? If so please explain…_____.
6) Have you ever been warned against taking any drug or medication?

   _____.
7) Do you bruise easily or bleed abnormally?_____.
8) Do you require pre-medication for dental treatment?_____.

Medical History

1) Have you ever had an organ implants or medical implants?_____.
2) Have you ever tested positive for HIV/AIDS?_____.
3) Do you have any of the following? Please check all that apply.

☐ Heart Murmur or Mitral Valve Prolapse	☐ Stomach/ Intestinal Problems/Ulcers	☐ Joint Replacement(hip/knee/etc.)
☐ Mental or Nervous Disorder	☐ High Blood Pressure	☐ Low Blood Pressure
☐ Hyper (hypo) Glycemia	☐ Cortisone/Steroid Therapy	☐ Malignant Hyperthermia
☐ Drug/Alcohol Dependency	☐ Venereal Disease	☐ Lung Disease (asthma)
☐ Thyroid Disease	☐ Arthritis or Rheumatism	☐ Scarlet or Rheumatic Fever
☐ Cancer/Chemotherapy	☐ Epilepsy or Seizures	☐ Liver Disease
☐ Heart Attack	☐ Cold Sores	☐ Jaundice
☐ Tuberculosis	☐ Hepatitis A,B,C	☐ Herpes
☐ Sinus Trouble	☐ Stroke	☐ Kidney Problems
☐ Emphysema	☐ Glaucoma	☐ Diabetes

☐ Other_____.

4) Do you use tobacco products? _____.
5) Is there anything in addition that you think the doctor or staff should know about?
_____.

Women Only:

1) Are you pregnant or suspect you might be? If so, what month are you in?_____.
2) Are you nursing?_____.

Dental History:

1) Is there a dental problem you would like to take care of as soon as possible? _____.
2) Do you see a dentist regularly?_____.
3) How often do you brush your teeth? _____. Floss?_____.
4) Do your gums bleed easily?_____. Do you have bad breath at times? _____.
5) Are your teeth sensitive to ☐ Hot ☐ Cold ☐ Biting ☐ Sweets?
6) Have you ever had jaw joint surgery? _____. Do you have pain in jaw joints or suffer from headaches? _____.
7) Does any part of your jaw hurt when clenched? Or pop when opened widely? _____.
8) Do you grind or clench your teeth during the day or night? _____.
9) Have you ever experienced any growths or sore spots in your mouth? If so, where? _____.
10) Are you satisfied with the appearance of your teeth?_____.

Privacy Act Notification: I have been informed of the privacy policy of this office and understand that all the information I have supplied will be used and disclosed as set out within this office policy.

Office Policy: Your appointment time will be reserved for you. If you **are unable to keep your appointment we require 48 hours' notice, otherwise it may be necessary to charge you for the time lost.**

Patient Release: I, the undersigned certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as maybe necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine, and I will assume responsibility for fees associated with these services.

Patient Signature _____. Date: _____ Reviewing Dentist: _____.
(Parent if patient is under 18 years old)