Health History - Please fill out as accurately as possible PID _____

ABLE DENTAL GROUP

Name: _____ AHC # _____

DOB: _____ Gender: M F Height: _____ Weight: _____

Legal guardian / Custodial (if applicable) : _____

Address: _____

City/Prov: _____ Postal Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____

Emergency Contact: _____ Relation: _____ Emergency Phone: _____

Referred by: _____ Medical Doctor: _____ Clinic: _____

Do you have or have you had any of the following?

YES	NO	
☐	☐	Fainting spells or seizures: eg. Epilepsy, stroke
☐	☐	Tuberculosis
☐	☐	High / low blood pressure
☐	☐	Heart condition / murmur / atrial fibrillation
☐	☐	Heart attack (date _____)
☐	☐	Rheumatic fever, scarlet fever, joint replacements
☐	☐	Lung or breathing disorder, asthma
☐	☐	Ulcers
☐	☐	Do you have a history of substance abuse?

YES	NO	
☐	☐	Diabetes Type _____
☐	☐	Blood disorders / Anemia / Problem Clotting
☐	☐	HIV infection or AIDS
☐	☐	Hepatitis (A,B,C), jaundice or liver disease
☐	☐	Mental health disorder
☐	☐	Arthritis Type _____
☐	☐	Cancer / Tumors / Growths
☐	☐	Do you Smoke? _____ # per day
☐	☐	Do you have a history of sleep apnea?
☐	☐	Are you pregnant?

Is there anything else we should know about your medical history?

_____

ALLERGIES: _____

MEDICATIONS PRESENTLY TAKING: (List on reverse if necessary or give copy of medical list)

Drug: _____ For: _____ Drug: _____ For: _____

Drug: _____ For: _____ Drug: _____ For: _____

Notes & Other Information: _____

- **Have you had an operation or been put to sleep in the past? (Circle) Yes No**
- **Is there a family history of: life threatening anesthetic complications, abnormal reactions to muscle relaxants,malignant hyperthermia or muscle problems (myopathy or muscular dystrophy)?** _____
- **When was your last dental exam (if at a different clinic?)** _____

Date of last dental x-rays? (if at a different clinic?) _____

Insurance Information

Primary Plan: 1st policy holder date of birth: _____
Policy Holder:
Employer:
Insurance Co:
Plan Group#
Certificate #

Secondary Plan: 2nd policy holder date of birth: _____
Relationship _____
Policy Holder:
Employer:
Insurance Co.
Plan Group#
Certificate #

Patient certification - I hereby certify that this medical and dental history is accurate and complete to the best of my knowledge. I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic, further medications, anesthetics or IV sedation as indicated. I also consent to the collection, use and disclosure of myself, my child's, or my ward's personal information as set out in the Personal Information Consent Form which I have read. **I have full decision making authority for the above listed minor or ward of the court.**

Patient(Parent, Guardian) Signature _____ **Date** _____