

MEDICAL QUESTIONNAIRE

BURLINGTON PERIODONTICS

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ALL INFORMATION GIVEN WILL BE TREATED AS STRICTLY CONFIDENTIAL

Full Name:	Date of birth (mm/dd/yy):
Address (please include city):	Postal Code:
Home phone number:	Business phone number:
Cell phone number:	Email address:
Medical doctor's name:	Phone number:
Medical doctor's address:	

Notes:

To provide the best possible care for our patients, all patients are asked to fill out this questionnaire. Please answer the following questions as accurately as possible. If you have any questions, please ask for assistance.

1. Are you being treated for any medical condition at the present or have you been treated within the past year?..... Yes No
If so why? _____
2. Was your last medical check-up within the past one year? Yes No
3. Do you have any heart (heart surgery, artificial valve/valve repair, congenital heart disease) or blood pressure problems?..... Yes No
4. Have you had a heart attack or stroke? Yes No
5. Are you taking any medications of any kind? Yes No
If yes, please list what kinds: _____
6. Do you take any blood thinners (e.g. Coumadin, Pradax, Xarelto, Eliquis, Clopidogrel, Aspirin or other)?..... Yes No
7. Do you have allergies (e.g. Penicillin? latex?) Yes No
If yes, please list: _____
8. Have you ever had reactions to any medicines or injections? Yes No
If yes, please list: _____

MEDICAL QUESTIONNAIRE CONTINUED

9. Do you have Hepatitis, jaundice or liver disease? Yes No

10. Do you have any condition that could affect your immune system?
(e.g. Leukemia, AIDS, HIV infection?)..... Yes No

11. Do you have any tendency to bruise or bleed easily?..... Yes No

12. Have you ever been hospitalized for any illness/operations?..... Yes No
If yes, for what: _____

13. Do you have diabetes?..... Yes No

14. For women only, are you pregnant?..... Yes No

15. Have you ever had any of the following?
 Chest pain Shortness of breath Lung disease Bone strengthening pills e.g. Actonel, Prolia
 Tuberculosis Asthma Cancer Steroid therapy Diabetes Stomach ulcers Prosthetic joints
 Arthritis Seizures Kidney disease Osteoporosis None

16. Do you have any other conditions not listed above?..... Yes No
If yes, for what: _____

17. Are there any diseases or medical problems that run in your family?
(e.g. Diabetes, cancer or heart disease) Yes No
If yes, what: _____

18. How often do you brush your teeth? _____ How often do you floss your teeth? _____

19. Are you nervous during dental treatment? Yes No
If yes, how nervous are you? 1 2 3 4 5 Very nervous

20. Is there anything in particular that makes you nervous with dental treatment? Yes No
If yes, what: _____

21. Do you smoke Yes No Quit # Packs: _____ # Years: _____

22. Do you drink alcoholic beverages on a regular basis?
..... Yes No

23. Do you use recreational drugs?..... Yes No

I acknowledge that the information given above is true to the best of my knowledge and that the questions have been reviewed with me. Should there be any change to my present health status in the future, I will advise the clinic staff. I have been informed that my physician may be contacted by letter or telephone in order to complete details of my medical history. I hereby consent to my physician providing the clinic with any information in this regard, which may help ensure safe dental treatment.

Signature: _____ Date: _____



Clinic policies and regulations for patients

Fees quoted are estimates only and subject to change. It is required that payment be made at each visit.

For those with dental insurance, required payment must be made to the clinic first and the specific treatment finished before a claim form is completed.

Appointments must be kept punctually. **Forty-Eight hours' notice must be given** if cancellation or change of appointment is necessary, a \$50 fee will be applied. Poor patient attendance will result in patient dismissal from the clinic.

Parents may attend with their children who are receiving dental care, provided the supervising staff member has given them permission and they agree to follow the rules of conduct as presented by the staff. If they do not follow the rules of conduct, as presented they may then be asked to leave the clinic and wait in the reception area. If they refuse to do this we will discontinue the treatment of their child.

Children are not allowed in adult clinic areas with parents who are receiving treatment and are not allowed in waiting areas unattended

Parents are required to provide supervision at all times for children not being treated

Patients unable to speak or understand English must be accompanied by an interpreter at every appointment.

Treatment will be discontinued if any patient does not comply with the above regulations

Consent for treatment

I hereby give consent to Dr. Thang to provide basic preliminary dental care, the need for and the cost of which will be explained to me before it is delivered. This may include teeth cleaning, specific investigations, oral care advice, dental implant surgery and the treatment of periodontal diseases. This may include the taking of records, radiographs and photographs, which may be used for teaching and publication purposes, and the administration of necessary anaesthetics and medications.

I have also read and understand the clinic policies and regulations for patients printed above and agree to abide by them

As to fees for these services, I agree to make payments as treatment progresses except for those procedures requiring laboratory services. For these services I shall pay at least one half the total fee before the treatment is begun and the balance before insertion of the restoration. I am also aware that there may have to be revisions in the costs for treatment of long duration. These revisions will be discussed with me before the treatment has begun

Signature of: _____

Signature of witness: _____ Date: _____