Dr. Victor Spicer Dental

Medical History

102-10050 112 Street
Edmonton Alberta, T5K 1L9
(780) 482-2288

Full Name: Phone:

Martial Status: Gender: DOB:

Full Address:

Occupation: Work Phone: Cell Phone:

Are you covered by any type of dental insurance? (mark if yes)

Insurance Company Name: Policy Number:

Referred by: Physician Name: Phone:

Please answer the following questions **Yes** **No**

1. What is your main dental concern?
2. Are you presently in good health?
3. Are you presently under the care of a physician?
4. Are you taking any medicines or drugs at the present?
5. Have you experienced any undue fatigue or loss of energy lately?
6. Has there been any recent changes in your weight, thirst, or appetite?
7. Are you on any special diet?
8. Do you experience any difficulty in keeping comfortable at normal room temperature?
9. Do you have any difficulty sleeping?
10. Do you bleed or bruise abnormally?
11. Have you had any allergies? i.e. hay fever, asthma

    Please specify:
12. Have you ever experienced fainting, shortness of breath, chest pains, or swollen ankles?
13. Do you have heart disease or a heart murmur?
14. Have you ever had or been treated for any of the following:

Heart Trouble	High Blood Pressure	Thyroid Trouble	Blood Disorders
Rheumatic Fever	HIV	Tuberculosis	Anaemia
Rheumatic Heart Disease	Steroid Therapy	Hepatitis A B C	Stomach Troubles
Liver Trouble	Diabetes	Cancer	Ulcer
Stroke	Epilepsy	Lung Disease	Jaundice

15. Have you had a medical examination in the last year?
16. Is there anything that the dentist should know regarding your medical history that has not been mentioned?

    Please specify:
17. WOMEN ONLY: Are you pregnant? What month?

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Please answer the following questions	**Yes**	**No**
1. Name of last dentist?		
2. When was your last dental visit?		
What was done at that visit?		
3. Have you ever had a full mouth series of x-rays? What year?		
4. Do any of your teeth ache?		
5. Do your gums bleed when you brush?		
6. Have you ever had any teeth extracted?		
Were there any complications involved?		

PERMIT FOR OPERATIONS

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anaesthetic as indicated and I will assume responsibility for fees associated with those procedures.

Patient's Signature: Date:

OFFICE POLICY

Unless other arrangements are made, payment is due when services are performed at each visit. If you have to change your reserved appointment, at least 24 hours notice must be given, otherwise a charge will be made.

COMMENTS

SEND FORM