

Dr. Tom Shackleton D.D.S.

General Dentist

PRACTICE LIMITED TO ENDODONTICS

MONTH DAY YR.

Patient Information Record

ACCOUNT NUMBER

MR. MRS. MISS MS. LAST NAME FIRST INITIAL ADDRESS CITY TOWN PROVINCE POSTAL CODE RESIDENCE PHONE BUSINESS PHONE DATE OF BIRTH M/ DAY/ YR/ OCCUPATION EMPLOYER EMERGENCY CONTACT NAME RELATIONSHIP TELEPHONE REGULAR OR REFERRING DENTIST

MEDICAL QUESTIONNAIRE:

- 1. Have you ever had a serious illness requiring hospitalization or surgery?
2. List any prescription or non-prescription medicine you take regularly.
3. Do you have any allergies?
4. Do any allergic reactions result in headache, shortness of breath, chest constriction or nausea?
5. Have you been warned against taking any drug or medication
6. Do you have or have you ever had any of the following?
7. Do you bruise easily or bleed abnormally?
8. Do you have any blood disorder such as anaemia (thin blood), thalassaemia (major, minor)?
9. Have you ever had radiation treatment or chemotherapy?
10. Have you ever had any injury, surgery or x-ray therapy to your face or jaws?
11. Do you have frequent headaches, ear/throat infections or hearing difficulties?
12. Do you experience shortness of breath or chest pains?
13. Have you had any organ transplants or medical implants?
14. Is there anything else about yourself that the doctor should know about?
15. WOMEN ONLY - Are you pregnant? If so, what month are you in?
16. Physician Phone

TO AVOID COMPLICATIONS, PLEASE NOTIFY OUR OFFICE OF ANY CHANGE IN YOUR MEDICAL CONDITION

INFORMED CONSENT/GENERAL RELEASE:

I have answered the questions on this form and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding these questions and I consent to my physician being contacted if necessary. I authorize the dentist to perform the procedures and services necessary including the use of anaesthetic. I also authorize the communication of information related to the coverage of services described on this form to the named dentist.

Signature Patient Parent Guardian Month/ Day/ Year/