CLIENT REGISTRATION April 6, 2019

MEDICAL ALERT

Client information

Client name: If minor, parent name:

Address: **Care Card #:**

City:	Prov.:	Postal code:
Phone (H):	Other phone:	Birthdate: day/ month /

Do you have any special concerns regarding your exam and treatment today? yes ☐ no ☐

____

Medical History

Medical doctor's name ______________________

Have you been hospitalized within the last year? ______

Reason: ______________________

Do you have any general health issues? ______________

Explain: ______________________

Do you routinely take any medication?

List: ______________________

	Yes	No
Do you need antibiotics before dental treatment?		
Artificial joint or prostheses ______________ date ______________	☐	☐
Tested HIV positive ______________	☐	☐
Hepatitis A / B / C (circle) ______________	☐	☐

Have you had any of the following:	**Yes**
Allergies to anaesthetics ______________	☐
Any unusual reaction or allergy to latex ______	☐
Heart problems or stroke ______________	☐
Blood pressure high / low (circle) ______________	☐
Rheumatic fever or rheumatic heart ______	☐
Prolonged bleeding from a minor cut ______	☐
Anemia ______________	☐
Liver problems ______________	☐
Kidney or thyroid problems ______________	☐
Stomach problems ______________	☐
Diabetes ______________	☐
Tuberculosis or lung disease ______________	☐
Arthritis or rheumatism ______________	☐
Asthma ______________	☐
Radiation Therapy ______________	☐
WOMEN Are you (possibly) pregnant ______	☐

I, the undersigned, certify that all of the above medical information provided is true to the best of my knowledge and I have knowingly ommitted any information. I also consent to my physician and / or dentist being contacted, including the sharing of radiographs and treatment data, as the information may be required for my dental hygiene care.

CLIENT'S or guardian's signature: ______________________ **Date:** ______________

TREATMENT RECORD

Office use only

Client gives Informed consent to exam / tx ☐

EO: WNL, or

IO: WNL, or

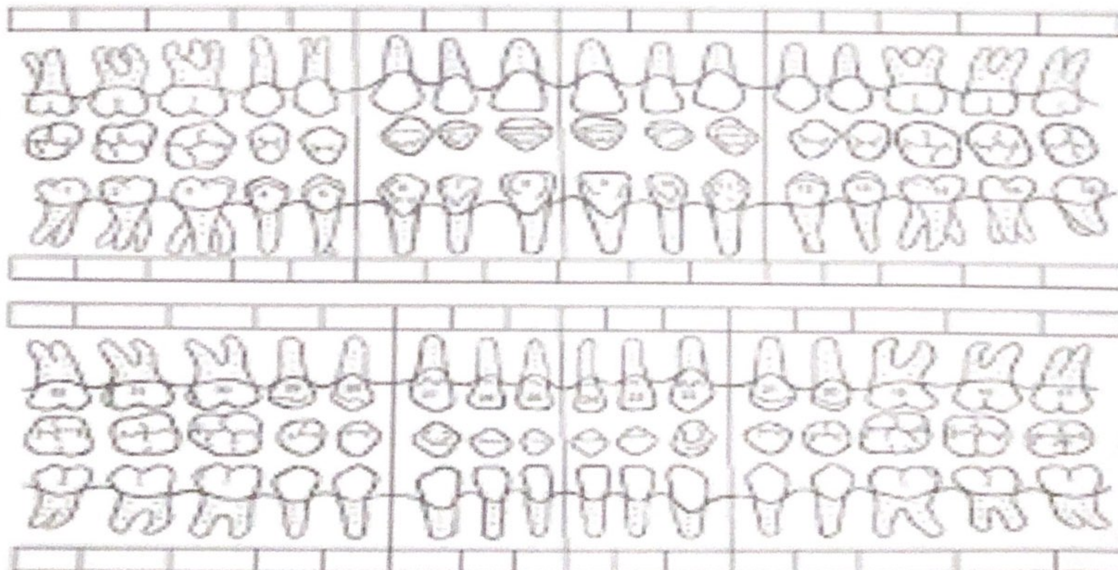
CC:

Referral recommendation:

Recommended referral(s): **sent / given to cli**

☐ ☐

☐ ☐



Treatment given to