Winkler Dental Clinic

reception@winklerdentalclinic.com www.winklerdentalclinic.com

Samantha Klassen Dental Corp | Box 1689 / 500 Main St. N • Winkler, MB R6W-4B5 (204)325-4343

Name (first and last)

Gender:

☐ Male ☐ Female ☐ Other

Status:

☐ Child ☐ Single ☐ Married ☐ Other

What is the date (or approximate date) of your last MEDICAL/FAMILY doctor's appointment?

Who is your medical doctor and what is the name of the clinic?

What is the name of your preferred pharmacy?

Please mark the box if your response is yes to any of the following questions:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Are you currently taking any prescription or non-prescription medications?

Please explain any items checked above and provide list of medications:
(if unsure of medications, please notify reception and we can request a list from your pharmacy)

WOMEN ONLY: If pregnant, when is your due date? _____

- [ ] *Pre-Med(antibiotic)
- [ ] Acid Reflux
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Atrial Fibrillation
- [ ] Cancer(past/present)
- [ ] Cognitive Delay
- [ ] Diabetes
- [ ] Excessive Bleeding
- [ ] Gastro-Intestinal
- [ ] Head Injury
- [ ] Hepatitis A
- [ ] Jaundice
- [ ] Mental Health Issue
- [ ] Parkinsons
- [ ] Rheumatic Fever
- [ ] Skin Rash
- [ ] Tuberculosis
- [ ] *PreMed(antianxiety)
- [ ] Allergy - Codeine
- [ ] Allergy- Amoxicillin
- [ ] Arthritis
- [ ] Autism
- [ ] Celiac
- [ ] Contraceptive Use
- [ ] Dizziness/Fainting
- [ ] Excessive Bruising
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Hepatitis B
- [ ] Kidney Disease
- [ ] Multiple Sclerosis
- [ ] Pregnancy
- [ ] Rheumatism
- [ ] Stroke
- [ ] Tumors
- [ ] *See Patient Notes
- [ ] Allergy - Latex
- [ ] Allergy-Local Anesth
- [ ] Artificial Joints
- [ ] Blood Disorder
- [ ] Chronic Migraines
- [ ] Crohn's disease
- [ ] Emphysema
- [ ] Fibromyalgia
- [ ] HIV+ (AIDS)
- [ ] Heart Murmur
- [ ] Hepatitis C
- [ ] Liver Disease
- [ ] Nervous Disorders
- [ ] Radiation Treatment
- [ ] STD
- [ ] TMD
- [ ] Ulcers
- [ ] ADHD
- [ ] Allergy - Other
- [ ] Allergy-Penicillin
- [ ] Asthma
- [ ] COPD
- [ ] Clotting Disorder
- [ ] Dental Anxiety
- [ ] Epilepsy
- [ ] Gag reflex
- [ ] Hard To Freeze
- [ ] Heart Surgery
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Pacemaker
- [ ] Respiratory Problems
- [ ] Sinus Problems
- [ ] Thyroid Disease

Please indicate any other health conditions, diseases or allergies not listed above that we should be aware of.

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_____

- [ ] **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids with my verbal consent at each appointment.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Please bring to front reception for electronic signature.

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Medical & Dental History Form

Response Date: _____