Millcroft Dental Care
for Family and Cosmetic Dentistry

Please be advised all information is private and confidential
Please be sure to bring your insurance information to your first visit

We welcome you to our dental practice.

Patient information (Adult Information)

☑ Mr ☐ Mrs ☐ Miss ☐ Ms

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: Day _____ Month: _____ Year _____

Phone Number: Home: _____ Cell: _____

Email: _____

Preferred Contact Method (please check one) ☐ Text ☐ Email ☐ Cell ☐ Home

How did you hear about us? (please check one) ☐ Flyers ☐ Drive/Walk by ☐ Online ☐ Friends and family ☐ Other

Emergency Contact Information

Emergency Contact Name: _____

Phone: _____ Relationship: _____

Today's Visit

Reason for this appointment? _____

Do you have dental insurance? ☐ Yes ☐ No

Your Medical History

Family Physician: _____ Phone Number: _____

Address: _____

City: _____ Postal Code: _____

Specialist: _____ Phone Number: _____

Date of your last physical exam: _____ Date of your last visit with your doctor: _____

Would you consider yourself to be in good health? ☐ Yes ☐ No

Have you been hospitalized in the past 2 years? ☐ Yes ☐ No

Reason: _____

Have you had any surgeries: ☐ Yes ☐ No

Reason: _____

WOMEN only: ☐ Yes ☐ No

Please list all medications you are currently taking: _____

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Medical Conditions

Please indicate any conditions you currently have or have had in the past:

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Stroke
- ☐ Heart Problems
- ☐ Artificial Heart Valve
- ☐ Mitral Valve Prolapse
- ☐ Heart Attack
- ☐ Blood/Bleeding Disorders
- ☐ Angina Pectoris
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Arthritis/Gout
- ☐ Thyroid Disease
- ☐ Pacemaker
- ☐ AIDS (HIV)
- ☐ Anemia
- ☐ Asthma
- ☐ Cold sores
- ☐ Liver Disease (Hepatitis A, B, C)
- ☐ Mental/Nervous Disorders
- ☐ Fainting/Dizziness
- ☐ Sinus Trouble
- ☐ Heart Palpitations
- ☐ Epilepsy/Seizures
- ☐ Malignant Hyperthermia
- ☐ Crohn's Disease
- ☐ Ulcers/Stomach concerns
- ☐ Lung disease
- ☐ Drug/Alcohol Addiction
- ☐ Malignant Hyperthermia
- ☐ Congestive Heart Failure
- ☐ Bleeding disorder
- ☐ Headachces
- ☐ Hernia
- ☐ Artificial Joints
- ☐ Hip/knee replacement
- ☐ Emphysema

Are you taking blood thinners? (*Warfarin/Coumadin/Plavix/Aspirin/Other*) ☐ Yes ☐ No

List: _____

Are there any other medical concerns we should be aware of?

_____

Allergies and Reactions

Please indicate which medications or materials you are allergic to, or have had a reaction to in the past:

- ☐ Aspirin (ASA)
- ☐ Ibuprofen (ADVIL)
- ☐ Acetaminophen (TYLENOL)
- ☐ Codeine (TYLENOL 1,2 or 3)
- ☐ Percocet/Oxycocet
- ☐ Tetracycline
- ☐ Penicillin/Amoxicillin/Ampicillin
- ☐ Erythromycin
- ☐ Clindamycin
- ☐ Local Anaesthetic (Freezing)
- ☐ Latex
- ☐ Nitrous Oxide
- ☐ Chlorhexidine (PERIDEX)
- ☐ Metal Allergy
- ☐ Cephalosporins (KEFLEX)
- ☐ Sulfa Drugs

Other drugs or material allergies not listed above; _____

Patient Signature: _____ Dentist Signature: _____

Date: _____

For office use only

Insurance Information:

Policy Number: _____ ID Number: _____

Policy holder _____ Policy holder DOB _____