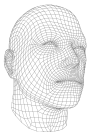

GREAT • LAKES
ORAL & MAXILLOFACIAL
SURGERY CENTRE

1825 MANNING ROAD • RR#1 • TECUMSEH • ON • N8N2L9
PHONE 519.979.7227 FAX 519.979.1956

NAME _____ AGE _____
LAST FIRST MIDDLE TITLE

ADDRESS _____
NUMBER STREET CITY POSTAL CODE

HOME PHONE _____ BUSINESS/MOBILE PHONE _____

SEX _____ HEIGHT _____ WEIGHT _____ OCCUPATION _____

DATE OF BIRTH _____ HEALTH CARD NUMBER _____ EXPIRY DATE _____
MONTH DAY YEAR

FAMILY DENTIST _____ ORTHODONTIST _____

FAMILY DOCTOR _____ LAST VISIT _____

CLOSEST RELATIVE _____ PHONE _____
LAST FIRST RELATION

NAME OF DENTAL INSURANCE _____ EMPLOYED BY _____

1. Are you being treated for any medical conditions?

If so, why? _____ Yes No

2. Are you taking any medication?

If yes, please list. _____ Yes No

3. Do you have any allergies? If yes, please list and explain.

(eg. penicillin, latex, foods) _____ Yes No

4. Have you ever had an adverse or peculiar reaction to any medication or injection?

If yes please explain. _____ Yes No

5. Do you have or have you ever had asthma or bronchitis? Yes No

_____

6. Do you have or have you had any heart or blood pressure problems? Yes No

Please list. _____

7. Do you have or have you had a heart murmur, mitral valve prolapse, rheumatic fever or prosthetic heart valve? Yes No

Please list. _____

9. Do you have a prosthetic or artifical joint? Yes No

Please list _____

10. Do you have any conditions or therapies that could affect your immune system? Yes No

If yes, please list or circle below _____

(eg. Leukemia, AIDS, HIV, radiotherapy, chemotherapy, steriods)

11. Do you have or have you had a bleeding problem, bleeding disorder or on a bloodthinner? Yes No

Please list _____

12. Do you consume energy drinks (Red bull, Monster, Rockstar) or body building/weight loss supplements (Ephedrine) Yes No

If yes, how much _____

13. Have you ever had Hepatitis, Jaundice or Liver Disease? Yes No

If yes, please circle one or more _____

14. Have you ever been hospitalized for any illnesses or operations? Yes No

If yes, please list and include year _____

15. Do you have or have you ever had any of the following? Please circle.

Chest pain	Shortness of breath	Pacemaker	Steroid therapy
Seizures(epilepsy)	Heart attack	Breathing problems	Diabetes
Kidney disease	Drug/alcohol dependency	Stroke	Stomach ulcers
Tuberculosis	Cancer	Prosthetic heart valve	Arthritis
Thyroid disease	Psychiatric care	Transplant	Sleep Apnea
			Malignant Hyperthermia

16. Please list any conditions or diseases not listed above that you have or have had.

_____

17. Do you smoke or chew tobacco products? Yes No

If yes, how much _____

I, the undersigned give permission for the performance of the contemplated or any necessary surgery and to send any reports to the referring Dentist/Physician.

Patient signature _____ Date _____

I acknowledge that I have read a copy of the office's Notice of Privacy Practice and Rights and understand my privacy rights and the office's privacy policies.

I agree that Great Lakes Oral and Maxillofacial surgical centre can collect, use and disclose personal information as set out in the Notice of Privacy Practice and Rights.

Patient signature _____ Date _____

I authorize release, to my dental benefits plans administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of the information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revoked the same.

Patient signature _____ Date _____