Sedation Dental Group

Dentistry under IV Sedation/General Anesthesia

Patient Information

- Name: _____ Birthday: YY _____ MM _____ DD _____
- Address: _____ City: _____ Postal Code: _____
- Mobile#: (_____)_____-_____ Home #: (_____)_____-_____ E-mail: _____
- Emergency Contact Information: Name:_____ Contact #:(_____)_____ Relationship:_____
- Family Dr:_____ CareCard#:_____ Last Dental Visit Year:_____
- How did you hear about us? ☐Website ☐Family ☐Friend ☐Walk-in ☐ Referred by dentist: Dr._____ ☐Other:_____)

Insurance Information

Dental Insurance: ☐NO

☐ 1st Private Insurance (□Manulife □Sunlife □GreatWestLife □BlueCross □Green Shield/ _____)

☐ 2nd Private Insurance (□Manulife □Sunlife □GreatWestLife □BlueCross □Green Shield/ _____)

☐ Ministry (□Healthy Kids □BCEA-Adult □Disability □Emergency

☐ NIHB #: _____

Medical History (Please check off the box)

	Yes	No		Yes	No		Yes	No
AIDS	☐	☐	Alzheimer	☐	☐	Artificial heart valve	☐	☐
Angina pectoris	☐	☐	Arthritis/rheumatism	☐	☐	Cancer	☐	☐
Artificial joints	☐	☐	Asthma	☐	☐	Congenital heart lesions	☐	☐
Cerebral palsy	☐	☐	Bronchitis	☐	☐	Diabetes	☐	☐
Congestive heart failure	☐	☐	Chest pains	☐	☐	Heart pacemaker	☐	☐
Glaucoma	☐	☐	Cortisone/Steroid therapy	☐	☐	Hemophilia	☐	☐
Heart disease or attack	☐	☐	Epilepsy/ Seizures	☐	☐	Hepatitis C	☐	☐
Hepatitis A	☐	☐	Heart murmur	☐	☐	Hyper (hypo) glycaemia	☐	☐
Herpes	☐	☐	Heart surgery	☐	☐	Leukemia	☐	☐
Hypertension	☐	☐	Hepatitis B	☐	☐	Mitral valve prolapse	☐	☐
Liver disease	☐	☐	Hodgkin's disease	☐	☐	Organ transplant	☐	☐
Osteoporosis	☐	☐	Kidney disease	☐	☐	Positive testing for HIV	☐	☐
Radiation/Chemotherapy	☐	☐	Medical implant	☐	☐	Rheumatic / scarlet fever	☐	☐
Thyroid disease	☐	☐	Psychiatric treatment	☐	☐	Stroke	☐	☐
Venereal disease	☐	☐	Tuberculosis	☐	☐	Other: _____		

- Have you ever had I.V. sedation in your life time? ☐ No ☐ Yes, When? & Why? _____
- Are you being treated for any medical condition at present or within the past two years? ☐ No ☐ Yes _____
- Have you been hospitalized in the last five years? ☐ No ☐ Yes _____
- Are you taking any prescription or non-prescription drugs? ☐ No ☐ Yes_____
- Do you have any sensitivities or allergies to medication? ☐ No ☐ Yes_____
- **Women only**
  - Are you pregnant or suspect you might be? ☐ No ☐ Yes Delivery date? Y _____ M _____ D _____
  - Are you breastfeeding? ☐ No ☐ Yes
  - Are you taking any birth control pills? ☐ No ☐ Yes

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care.

Signature of Patient (19 Yrs or above): _____ Date: YY _____ MM _____ DD _____

Legal Guardian's Name: _____ Relationship: _____