Friends and Family Dental Health
105, 4000 Glenmore Court SE
Calgary AB T2C5R8

(403)236-5171

admin@ffdental.ca
FFdental.ca

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- ☐ 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)?
- ☐ Do you require the use of corrective lenses (contacts or glasses)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

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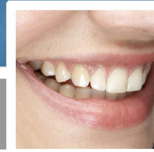
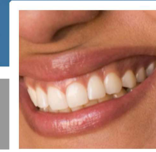
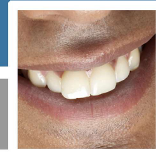




WOMEN ONLY: Are you pregnant?

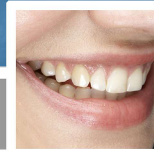
◯ Yes ◯ No

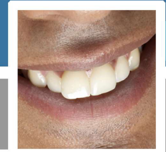
If Yes, when is the due date?

[ ]

Please indicate if you have experienced any of the following:

- [ ] *Pre-Medication
- [ ] *See Patient Notes
- [ ] Allergy - *See Notes
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Iodine
- [ ] Allergy - Latex
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy-Erythromycin
- [ ] Allergy-Local Anesth
- [ ] Anemia
- [ ] Anticoagulant Treatm
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Birth Control
- [ ] Bleeding Disorder
- [ ] Blood Born Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness/Fainting
- [ ] Emphysema/COPD
- [ ] Epilepsy
- [ ] Epinephrine Sensitiv
- [ ] Excessive Bruising
- [ ] Gastro-Intestinal
- [ ] Glaucoma
- [ ] Hard To Freeze
- [ ] Hay Fever
- [ ] Head Injury
- [ ] Hearing Impaired
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] HIGH Blood Pressure
- [ ] HIV+ (AIDS)
- [ ] HSV Herpes/Coldsore
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] LOW Blood Pressure
- [ ] Mental Disorders
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Rheumatoid Arthritis
- [ ] Sinus Problems
- [ ] STI
- [ ] Stomach Ulcers
- [ ] Stroke
- [ ] Substance Abuse
- [ ] Thyroid Disease





☐ TMJ Disorders ☐ Tuberculosis ☐ Tumors
☐ Wheelchair

Do you have any other health issues or allergies?

Are you currently taking any prescriptions or non-prescription medications? Please list:

Please check if you had any of the following conditions in the past month

☐ Frequent Diarrhea ☐ Undiagnosed Rash ☐ Persistant Cough

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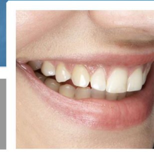

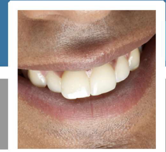

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

Are you happy with your smile?

○ Yes ○ No

If NO, what would you like to change?

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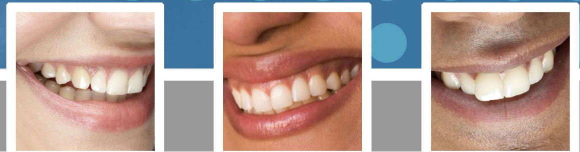

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

We require 2 business days advance notice if you would like to change your appointment. Changes must be made by speaking directly with our staff, and are not accepted via email or voicemail. The fee for missed appointments or short-notice cancellations is $100/hr.

While we do our best to faciltate reminder calls and/or emails, patients are responsible for the management of their appointments.

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 deemed appropriate.

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 understand that I am financially responsible for any outstanding balance for services provided. 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).

Signature of patient, parent, or guardian:

Signature: ______________________________ Date: [ ]

Relationship to Patient:______________________________

[ ]

Response Date: [ ]