Boisson Dental Group
Rooted in the Peace
boissondental.ca • 587-771-ROOT (7668)

Welcome to Our Practice

Patient Name: (Last)_____ (First) _____ MI _____

Gender: M/F Email Address: _____

Phone: (H)_____ (W)_____ Mobile _____

Mailing Address: _____

City: _____ Postal Code: _____

Birthdate: (d/m/y) _____

Insurance Information:

Policy Holder: _____Birthdate of Policy Holder: d/m/y _____

Insurance Company: _____

Group Number: _____Certificate (ID)Number _____

Secondary Insurance

Policy Holder: _____Birthdate of Policy Holder: d/m/y _____

Insurance Company: _____

Group Number: _____Certificate (ID)Number _____

Medical History

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Indicate which of the following conditions you have or have had. By checking the box, it will indicate a "Yes" response, leave it blank will indicate a "NO" response.

☐	Pre-Medication		Allergy (See Notes)		Allergy - Aspirin
☐	Allergy – Codeine		Allergy (Iodine)		Allergy - Latex
☐	Allergy - Penicillin		Allergy (Sulfa)		Allergy - Erythromycin
☐	Artificial Joints		Anemia		Arthritis
☐	Cancer		Asthma		Blood Disease
☐	Dizziness/Fainting		Contraceptive Use		Diabetes
☐	Excessive Bleeding		Emphysema		Epilepsy
☐	Glaucoma		Excessive Bruising		Gastro-Intestinal
☐	Head Injury		Hard to Freeze		Hay Fever
☐	Heart Murmur		Hearing Disabled		Heart Disease
☐	Hepatitis C		Hepatitis A		Hepatitis B
☐	Hives		High Blood Pressure		HIV + (AIDS)
☐	Liver Disease		Jaundice		Kidney Disease
☐	Multiple Sclerosis		Low Blood Pressure		Anxiety
☐	Pacemaker		Nervous Disorders		Other (add to notes)
☐	Respiratory Problems		Bisphosphonate Treatment (Fosamax) – Osteoporosis		Radiation Treatment
☐	Rheumatoid Arthritis		Rheumatic Fever		Rheumatism
☐	STD		Sinus Problems		Skin Rash
☐	Thyroid Disease		TMJ		Stroke
☐	Tumors		Ulcers		Tuberculosis
☐	Ever Been Hospitalized (illness or injury)		Subject to frequent headaches		Presently being treated for other illnesses
☐	Tobacco/Alcohol Use		Female: Birth control		Female: Currently Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Name of your physician and phone number: _____

What is your estimate of your general health? Excellent/Good/Fair/Poor (Circle one)

List all medications (prescription and non-prescription) including regular does of aspirin:

* By signing this form, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature: _____ Response Date: _____