U DENTAL

Dr. Ahmed Sharaf, D.D.S

www.udental.ca

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ON K2G 3J3 T: 613.228.3000
F: 613.228.3080

CONTACT INFORMATION

Name _____

Address _____

City _____ Province _____

Postal Code _____ Birthday _____

Home Phone _____ Cell Phone _____

Email _____

Best way to contact you to confirm appointments:

O Email O Text O Both

EMERGENCY CONTACT INFORMATION

Name _____

Relationship _____

Phone Number _____

Name of your Family Doctor _____

Phone Number _____

UPDATED MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality.

Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

_____

_____

Has there been any change in your general health in the past year? If yes, please explain.

_____

_____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

_____

_____

MEDICAL HISTORY

Do you have any allergies? Please list below:

_____

_____

Do you have or have you ever had any heart or blood Pressure problems? Y N

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart {i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? Y N

Do you have a prosthetic or artificial joint? Y N

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Y N

Do you have a bleeding problem/bleeding disorder? Y N

Do you have a pacemaker? Y N

Do you smoke or use a vaporizer? Y N

Have you ever been hospitalized for any illnesses or operations, if yes, please explain.

_____

_____

Please list any other medical conditions you have/had in the pa (i.e. diabetes, asthma, depression):

_____

_____

For women only:

Are you or could you be pregnant? Y N

Are you breastfeeding? Y N

Expected delivery date: _____

TREATMENT CONSENT

I, the undersigned, understand that the information contained in the medical history is important to my treatment. I certify that all of the information I have completed is correct and that I haven't knowingly omitted data.

Patient/Guardian Signature Date

_____

Dentist Signature Date

_____