



**HEALTH CARE**

Do you have a family doctor or nurse practitioner? YES  NO

Name: \_\_\_\_\_ Date of last medical checkup? \_\_\_\_\_

Are you pregnant? NO  YES  (expected due date): \_\_\_\_\_

Are you breast feeding \_\_\_\_\_

Have you had an **emergency department** visit in the last **2 months** for dental pain/infection?  
NO  YES

**Known Allergies or reactions to medications (explain):**

\_\_\_\_\_

**Known allergies or reactions to other e.g. environmental/food (explain):**

\_\_\_\_\_

Are you being treated for, or do you have any concerns with the following in the past year?

- |   |   |
|---|---|
| <input type="checkbox"/> Bleeding Problem/Disorder                                      | <input type="checkbox"/> Bone/Joint Problems/Arthritis/Osteoporosis |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Prosthetic or artificial joint             |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Diabetes                                   |
| <input type="checkbox"/> COPD/Lung Problems   | <input type="checkbox"/> Heart Attack                               |
| <input type="checkbox"/> Heart Disease/Heart Surgery/Heart Valve/Heart Murmur/Pacemaker |   |
| <input type="checkbox"/> Infective Endocarditis   |   |
| <input type="checkbox"/> Congenital Heart Disease (from birth)                          |   |
| <input type="checkbox"/> Immune System (HIV, Leukemia, Chemotherapy, Radiotherapy)      |   |
| <input type="checkbox"/> High Blood Pressure  |   |
| <input type="checkbox"/> Hepatitis/Jaundice/Liver Disease                               |   |
| <input type="checkbox"/> Cancer (of: _____)   |   |
| <input type="checkbox"/> Depression/Anxiety   |   |
| <input type="checkbox"/> Mental Health - Please describe: _____                         |   |
| <input type="checkbox"/> Addiction/dependence issues (to: _____)                        |   |

Do you have any conditions or diseases that have not been listed? If so please list:

\_\_\_\_\_

Do you take Aspirin or any Blood thinners? \_\_\_\_\_

Have you ever been told to take medication **before** a dental appointment?  Yes  No

Do you smoke? How many cigarettes/day: \_\_\_\_\_ No \_\_\_\_\_

**Medications – please list each (or attach a print-out from Pharmacy)**

Name of your preferred pharmacy: \_\_\_\_\_ Telephone# \_\_\_\_\_

Location: \_\_\_\_\_

Prescribed Medication	Dosage	How Often?
1		
2		
3		
4		
5		

**Over the Counter, Herbal, homeopathic or other health treatment products**

Name	Dosage	How Often?
1		
2		
3		
4		
5		

**By signing this agreement I agree that all of the above information is true to the best of my knowledge.**

Applicant Signature (client) \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

*Please Note: If signed by person **other than** applicant, indicate relationship (Parent/guardian signature is required if applicant is under the age of 16 years)*



**IMPORTANT INFORMATION ABOUT BQWCHC ORAL HEALTH PROGRAM**

- **An appointment must be made for your visit**
- **Please arrive 10 minutes prior to your appointment time**
- **We are a busy dental clinic. If you arrive more than 10 minutes late for your appointment, your appointment will need to be rescheduled**
- ***You MUST have your eligibility card (OW/ODSP/Healthy Smiles) with you when you arrive for your appointment. If you do not have your card, we will have to reschedule your appointment***
- **It is very important that you attend your appointments. If you need to cancel, please provide us with 24 hrs notice of a cancellation (613) 962-0000 x263. When you do not attend your appointments and do not provide us with notice, we are unable to give your appointment time to someone else, like you, who is in need of our services**
- **If you have two consecutive “no-shows” without reasonable explanation, we may give you a ‘wait period’ before you can be seen by us again, or may ask you to get dental care elsewhere.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_