Eid dentalclinic

Phone: 519-667-077 | Fax: 519-667-0778
Email: Somaya.Eid@Eiddentalclinic.ca
Address: 750 Base Line Road East, Unit #207, London, ON N6C 2R5

First Name Last Name Sex: ❑ Male ❑ Female

Y / N

❑/❑ Are you advised to take antibiotics prior to dental treatment?

❑/❑ Have you experienced a fast heart rate/ rush after dental anesthetics?

❑/❑ Do you have difficulty getting numb for dental treatment?

❑/❑ Have you had surgery or been hospitalized in the past five years?

❑/❑ Are you taking any blood thinners like Coumadin? If yes what are you taking?

❑/❑ Are you taking any medications for Osteoporosis (Bisphosphonates) like

Boniva, Actonel, Fosamax, Skelid, Aredia, Zometa, Reclast, Didronel?

For women check all that apply: ❑ I am or may be pregnant ❑ I am nursing ❑ I am taking birth control pills

Have you experienced an unusual reaction to any of the following?

❑ Latex ❑ Penicillin ❑ Erythromycin ❑ Vicodin, Lortab or Hydrocodone
❑ Sulfa ❑ Aspirin or other NSAIDs ❑ Local Anesthetic ❑ Codeine

Please list other medication allergies_____

choose all of the following that you may have had in the past or that currently apply to you:

❑ High Blood Pressure	❑ Prosthetic Joints/Implants	❑ Diabetes
❑ Heart Murmur	❑ Osteoporosis	❑Cancer
❑ Infective Endocarditis	❑ Fainting	❑ Radiation or Chemotherapy
❑ Congenital heart disease/ defects	❑ Pacemaker	❑ Surgery
❑ Artificial Heart Valves	❑ Low Blood Pressure	❑ Kidney problems
❑ Mitral Valve Prolapses	❑ Stroke	❑ Hepatitis
❑ Rheumatic Fever	❑ AIDS/ HIV	❑ Emotional disorders
❑ Heart Attack	❑ Lung problems or COPD	❑ Anemia
❑ Heart Surgery	❑ Asthma	❑ Thyroid problems
❑ Angina	❑ Breathing Difficulties	❑ Tuberculosis

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Dental Head and Neck:

Are/Were you in Pain? ❑ Yes ❑ No Are you currently in pain? ❑ Yes ❑ No

Rate of discomfort. Please circle: No pain ❑1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑7 ❑8 ❑ 9 ❑10 Severe Pain

Approximately when did you first notice the condition? _____

What have you done or happened since:_____

_____

_____

Medication Taken for the condition in question: ❑ Antibiotic ❑ Pain relief ❑other _____

_____

Circle that best describe your discomfort:

❑ Sharp ❑ Throbbing ❑ Dull ❑ Continuous Ache ❑ Comes and goes ❑ Diffuse ❑ Radiating

Pain to: ❑Hot ❑ Cold ❑ Chewing ❑ Sweets ❑ Laying Down ❑ Climbing Starirs Bending over

Please list any other medical concerns not listed above:

List all the medication currently taking or have taken within last two years:

Past Dental Experience:	❑ Good	❑ Average	❑ Bad
Past root canal Experience:	❑ Good	❑ Average	❑ Bad
Level of Dental Anxiety:	❑ Low:1-3	❑ Medium 3-6	❑ High7-10_

By signing this form, I consent Eid Dental Clinic to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations. By signing this form I also understand that it is my responsibility to notify the doctor of any changes in my health or medications before any treatment.

Patient Signature_____ Date_____