Dr. Nasrin Saba DDS
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We appreciate referrals. Whom may we thank for referring you? _____

Date: _____
Day/Month/Year

CONFIDENTIAL PATIENT INFORMATION

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. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Name: _____
Title First Middle Last

Address: _____
Apt Street City Prov. Postal Code

Home phone:_____ Cell: _____

Business:_____Email:_____

Occupation:_____ Place of Work:_____

Date of Birth (Day/Month/Year):_____

Dental Insurance: ☐ YES ☐ NO

Name of Company: _____

Person responsible for account: Same as above ☐ or _____

In case of emergency please notify: Name: _____

Relationship: _____ Phone: _____

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

1. Are you being treated for any medical condition at the present or have you been treated within the past year?
   ☐ YES ☐ NO ☐ NOT SURE If yes, why? _____
2. When was your last medical checkup?
3. Has there been any change in your general health in the past year?
   ☐ YES ☐ NO ☐ NOT SURE If yes, please explain. _____
4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
   ☐ YES ☐ NO ☐ NOT SURE
   If Yes, Please specify:
   Drug : _____ Reason: _____
   Drug: _____ Reason: _____
   Drug: _____ Reason: _____
   Drug: _____ Reason: _____
5. Do you have any allergies? :
   ☐ YES ☐ NO ☐ NOT SURE
   If Yes Please Specify: A) medications ☐ B) latex/rubber products ☐ C) other (e.g. hayfever, foods)
6. Have you ever had a peculiar or adverse reaction to any medicines or injections?
   ☐ YES ☐ NO ☐ NOT SURE If yes, please explain. _____
7. Do you have or have you ever had asthma?
   ☐ YES ☐ NO ☐ NOT SURE
8. Do you have or have you ever had any heart or blood pressure problems?
   ☐ YES ☐ NO ☐ NOT SURE
9. 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?
   ☐ YES ☐ NO ☐ NOT SURE
10. Do you have a prosthetic or artificial joint?
    ☐ YES ☐ NO ☐ NOT SURE
11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?
    ☐ YES ☐ NO ☐ NOT SURE

12. Have you ever had hepatitis, jaundice or liver disease?
□ YES □ NO □ NOT SURE
13. Do you have a bleeding problem or bleeding disorder?
□ YES □ NO □ NOT SURE
14. Have you ever been hospitalized for any illnesses or operations?
□ YES □ NO □ NOT SURE If yes, please explain.
15. Do you have or have you ever had any of the following? Please check.

□ chest pain, angina	□ heart attack	□ stroke	□ shortness of breath
□ rheumatic fever	□ mitral valve prolapse	□ heart murmur	□ pacemaker
□ lung disease	□ tuberculosis	□ diabetes	□ arthritis
□ cancer	□ steroid therapy	□ stomach ulcers	□ seizures (epilepsy)
□ kidney disease	□ thyroid disease	□ drug/alcohol dependency	□ osteoporosis medications (e.g. Fosamax - Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what?
□ YES □ NO □ NOT SURE
17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)
□ YES □ NO □ NOT SURE
18. Do you smoke or chew tobacco products?
□ YES □ NO □ NOT SURE
19. Are you nervous during dental treatment?
□ YES □ NO □ NOT SURE
20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
□ YES □ NO □ NOT SURE
21. Do you have any illness not included above? Please specify:
□ YES □ NO □ NOT SURE

DENTAL HISTORY

1.Are you having any discomfort at this time? □ YES □ NO
If yes, please explain._____
2.Have you been under regular care by a dentist? □ YES □ NO

3.Name of previous dentist:_____ Last dental visit_____

4.What was done at that time?_____
5.Do your gums feel tender or swollen? □ YES □ NO
6.Do you catch food between your teeth? □ YES □ NO
7.Do you wish to keep your natural teeth? □ YES □ NO
8.Have you ever had a problem with local and general anaesthetic? □ YES □ NO
9.Are you tense during dental visits? □ YES □ NO
10. Would you be interested in improving the appearance of your teeth? □ YES □ NO
11. Describe what you would like done with your teeth: _____

_____

12. Do you currently experience? (Please check)

□ loose teeth	□ sensitive teeth	□ headache	□ spaced or crooked teeth
□ unsatisfactory dentures	□ bad breath	□ neck pain	□ gagging
□ bleeding gums	□ sore gums	□ popping/clicking jaw	□ earache
□ unexplained nose bleeds	□ missing teeth		

GENERAL RELEASE

I, _____the undersigned, state that I have provided an accurate and complete medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding this medical-dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as maybe necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services to me or my dependents.

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE :_____

RESET PRINT SAVE

To email the from please save your form and send it manually to info@bankdentistry.com using your email service.