MEDICAL UPDATE

Name: _____ Date of Birth: _____ your email Address: _____

Residence Phone: _____ Cell Phone: _____ Work phone: _____

Address: _____ City: _____ Postal Code: _____

Emergency Contact Name: _____ Phone: _____ Alternative Phone: _____

Medical History

	Yes	No
• Asthma	_____	_____
• Anemia	_____	_____
• Abnormal Bleeding/Hemophilia	_____	_____
• Cancer Where: _____	_____	_____
• Diabetes	_____	_____
• Epilepsy/Seizures	_____	_____
• AIDS/HIV/Venereal Disease	_____	_____
• Ulcers/Colitis	_____	_____
• Gastro-Intestinal Problems	_____	_____
• High/Low Blood Pressure	_____	_____
• Liver Problems / Hepatitis	_____	_____
• Kidney Problems	_____	_____
• Lung Problems	_____	_____
• Sinus Troubles	_____	_____
• Smoker	_____	_____
• Thyroid Disorder Hyper/Hypo	_____	_____
• Tuberculosis	_____	_____
• Are you pregnant	_____	_____
• Recent Hip or Knee Replacement or Joint Replacement	_____	_____
• Heart Problems:		
○ Heart Attack	_____	_____
○ Stroke	_____	_____
○ Angina	_____	_____
○ Heart Surgery	_____	_____
○ Congenital Heart Defect	_____	_____

Comments: _____.

Any other medical conditions not mentioned? _____.

Are you taking any prescription or non prescription drugs YES OR NO

If yes please list: _____.

Are you **allergic** to any of the following? **Codeine:** YES___ NO___ **Penicillin:** YES___NO___ **Other:** YES___NO___

If yes please list? _____.

It is my responsibility to inform Mirzakhani Dentistry of any changes in my medical status. I authorize the dental staff to perform any necessary dental services during diagnosis and treatment with my informed consent. I authorize photographs and or X-rays to be taken of me and placed on my file as part of my records. I agree that Mirzakhani Dentistry can collect, use and disclose personal information about me as set out in the Ontario's personal health information protection act. (PHIPA). I authorize release, to my insurance company or plan administrator, the information contained in claims submitted electronically.

Signature: _____ **date:** _____.