Dr. Stephen Standish

CONFIDENTIAL **NEW PATIENT FORM / MEDICAL UPDATE**

Name:_____ Gender: Male / Female
Address:_____ Unit #: _____ Province: _____ Postal Code: _____
Cell Phone: ( )_____-_____ Email: _____
Home Phone: ( )_____-_____ Work Phone: ( )_____-_____ Ext:_____
Birthdate: _____ /_____ /_____ If child, name of parent: _____
day / month / year

Referred by: _____

Primary Insurance Company: _____ Plan Number: _____
Employer: _____ Certificate Number: _____
Secondary Insurance Company: _____ Plan Number: _____
Employer: _____ Certificate Number: _____

MEDICAL HISTORY

1. Do you have any allergies? YES NO If yes, please specify: _____
2. Are you allergic to any specific medication? YES NO If yes, please list: _____
3. Are you taking any medication now? YES NO If yes, please list (or provide a list from your pharmacy):

_____

4. Have you ever had rheumatic fever? YES NO
5. Do you have any artificial joints? YES NO
6. Do you have any prosthetic heart valves? YES NO
7. (Women only) Are you pregnant? YES NO
8. Do you have osteoporosis? YES NO If yes, what medication are you taking? _____
9. Do you have a serious illness now? Please specify: _____
10. Have you had a serious illness in the past? Please specify: _____
11. Have you ever had hepatitis A / B / C / HIV ? YES NO
12. Are you a smoker? YES NO
13. Approximately when was your last visit to the dentist? _____
14. Any specific dental problem you would like to discuss today? _____
15. Pharmacy : _____ Tel: _____
16. Medical doctor: _____ Tel: _____
17. In case of emergency, notify: _____ Tel: _____

Signature of patient: _____ Date: _____
(parent if child under 18)

MEDICAL HISTORY UPDATE (office use only)

Date	Same	Change	Date	Same	Change
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICAL HISTORY UPDATE (office use only)

Date	Same	Change	Date	Same	Change