DR. MARVIN BUDD
Welcome to Our Office

ACQUAINTANCE INFORMATION - Please Print

Last Name:_____ First Name:_____ Mr. Mrs. Miss. Ms. Dr.
Home Address:_____ Apt#: _____
City/Province: _____Postal Code: _____
Telephone Home: _____ Bus: _____ Cell: _____
Email: _____ Fax: _____
Birth date (dd/mm/yy): _____Age:_____ Sex: M / F Height: _____ Weight:_____
Ont. Health Card #_____ *or* Ont. Driver's Lic: __ _____
Employer: _____ Occupation: _____
If under 18 years of age, name of parent/guardian: _____
Whom may we thank for referring you? _____
Your personal dentist: _____Telephone: _____

INSURANCE INFORMATION

Do you have dental insurance? Yes___ No___
Subscriber's Name: _____
Relation to Patient: _____
Employer: _____
Birth date (dd/mm/yy): _____

Ins. Co. Name: _____
Policy/Group No:_____ Div:_____
I.D./Cert No:_____

Do you have secondary dental insurance? Yes___ No___
Subscriber's Name: _____
Relation to Patient: _____
Employer: _____
Birth date (dd/mm/yy): _____

Ins. Co. Name: _____
Policy No:_____ Div: _____
I.D./Cert No:_____

I authorize release of information contained in my claims to be submitted electronically (EDI) to my dental benefits plan.

Signature of patient, parent or guardian: _____ Date: _____

MEDICAL PRIORITY

Family Physician:_____Telephone:_____
Medical Specialist:_____Telephone:_____
In case of emergency, please contact: _____Relationship:_____
Telephone Home:_____ Bus:_____ Other:_____

CONFIDENTIAL HEALTH HISTORY

1. When did you last visit your family doctor? _____
2. Have you been treated recently by your family doctor? Yes___ No___
   If yes, please explain_____
3. Have you ever had any serious illness, recent surgery or been in the hospital?
   If yes, please explain_____
4. Are you taking any prescription or medication now? Please list all medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____

5. Please list any herbal or non-prescription supplements:

_____ _____ _____

6. Have you ever been told **not** to take any drug, medication or food? _____
7. Are you allergic to anything? (bananas, kiwi, other foods or medications, etc.)_____
8. Do you have a latex allergy? Yes___ No___
9. Have you had any unusual or allergic reaction to any of the following drugs? (Please circle)

   Penicillin Sulpha Cortisone (steroids) Local anaesthetics Barbiturates (sleeping pills) Sedatives

   Aspirin Codeine Other:_____

10. **Please circle any of the following, which you have had or have at present:**

Heart Failure	Anemia	Thyroid Disease	Jaundice
Heart Disease or Attack	Stroke	X-ray or Cobalt Treatment	Blood Transfusion
Angina Pectoris	Kidney Trouble	Chemotherapy	Drug Addiction
High Blood Pressure	Ulcers	Arthritis	Hemophilia
Heart Murmur	Emphysema	Osteoporosis	Cold Sores
Venereal Disease(Syphillis,Gonorrhea)	Rheumatic Fever	Cough	Cortisone Medicine
Congenital Heart Lesions	Tuberculosis (TB)	Glaucoma	Genital Herpes
Scarlet Fever	Asthma	Pain in Jaw Joints	Epilepsy or Seizures
Artificial Heart Valve	Hay Fever	Hepatitis A	Fainting or Dizzy Spells
Heart Pacemaker	Sinus Trouble	Hepatitis B	Nervousness
Heart Surgery	Allergies or Hives	Hepatitis C	Psychiatric Treatment
Artificial Joint (Hip,Knee,etc.)	Diabetes	Liver Disease	Sickle Cell Disease
Mitral Valve Prolapse	Cancer	**A.I.D.S./HIV**	Alcohol Dependency

11. Do you have, or have you had in the past, any disease or problem not listed above? _____
12. Is there any history of family disease? _____
13. Do you bruise easily or bleed profusely from a cut or injury? _____
14. Have you ever had any radiation treatments? _____
15. Do you smoke? Yes___ No___ If yes, what amount do you smoke? _____
16. Has your weight, appetite or energy level **dramatically** changed recently? _____
17. Do you have **frequent severe** headaches, earaches, ear/throat infections?_____
18. Have you ever had any injury or surgery to your face or jaws? _____
19. Do you wear eyeglasses or contact lenses?_____
20. Is there anything else about your health we should be aware of?_____

WOMEN ONLY : Are you taking oral contraceptives? Yes___ No___
Are you pregnant? Yes___ No___ Due Date:_____ Are you nursing? Yes___ No___

IT IS IMPORTANT THAT ANY CHANGE IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information.
I also give consent and understand that consultation with my medical doctor and dentist may be required.

Patient or Guardian Signature: _____Date: _____

Periodontist's Signature:_____Date: _____