Dr. Holly MacPherson
Dr. Travis McLean

NORTHSIDE DENTAL CLINIC

169 Main Street
Fredericton NB
506-458-9477
506-458-8953

Patient Information

Patient Name: ____ ☐ Male ☐ Female
Last First MI (Preferred Name)

Date of Birth: _____ __ ___________ Occupation/Employer: ______________________________

Email Address: ____

Phone (Home): ________________ (Work): ________________ (Cell):________________

Address: ____
Street Apartment #
____
City Province Postal Code

Dental Insurance YES/ NO *If yes please provide your dental insurance card*

Please take a moment to let us know about your medical history so that we may provide you with the best possible dental care in a way that watches out for your overall health and well-being.

Family physician's name & phone number:
____
Date of your last medical check-up:
____

Are you currently being treated for any medical condition or have you been treated within the past year? **YES** or **NO** If yes, please explain:
____
____

Do you have any allergies? **YES** or **NO**
If yes, please list:
Medications:________________________
Latex products:______________________
Other: _____________________________

Please list any medication(s) you are taking:
(including non-prescription)
____
____
____
____

Do you have, or have you ever had, any of the following? (please circle)

Asthma	High blood pressure	AIDS
Chemotherapy	Radiation	Hepatitis
Bleeding disorder	Angina	Rheumatic fever
Stroke	Joint replacement *Date:________	Heart attack *Date:__________
Pacemaker	Lung disease	Cancer
Steroid therapy	Diabetes	Ulcers
Arthritis	Seizures	Kidney Disease
Thyroid Disease	Drug/alcohol dependency	Osteoporosis medications

Women Only: Are you pregnant **YES/NO** Are you nursing **YES/NO**

PATIENT APPROVAL AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted pertinent information. I consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetic. I understand that any work needed will be fully discussed with me by the dentist prior to beginning treatment, including other treatment options. I understand that no treatment is always an option. I understand that I am personally responsible for payment at time of all dental services rendered even if my insurance coverage may not be all inclusive. I consent to my physician being contacted if necessary, as this information may be required for my dental care.

Patient (Parent, Guardian) Signature:_______________________________ Date:_____________

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING