NORTHSIDE DENTAL CLINIC

Dr. Holly MacPherson
Dr. Travis McLean
254 Main Street Fredericton NB
506-458-9477

PATIENT INFORMATION

Last Name: _____ First: _____ Mi: _____

Date of Birth: _____ (DD/MM/YYYY) ☐M ☐F Occupation: _____ Employer: _____

Address: _____ Work Phone: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Home Phone: _____ Cell: _____

MEDICAL INFORMATION

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

Family physician's name & phone number: _____

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** **Latex products?** ☐ **YES or** ☐ **NO** **Medications** ☐ **YES or** ☐ **NO**

If yes, please list: _____

_____

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

_____

Do you have, or have you ever had, any of the following?

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

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.

Please advise us in the future of any change in your medical history or any medications you may be taking.

Patient (Parent, Guardian) Signature: _____ Date: _____