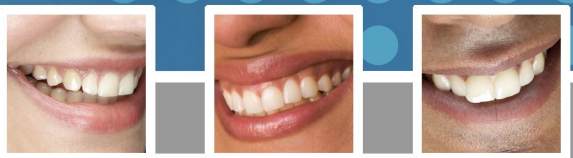
Winkler Dental Clinic
Samantha Klassen Dental Corp
Box 1689 / 500 Main St. N
Winkler MB R6W4B5
(204)325-4343
winklerdentalclinic@gmail.com
www.WinklerDentalClinic.com



Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

What is the reason for your dental visit today?

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?Are you currently taking any prescription or non-prescription medications?

Please list medications:

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

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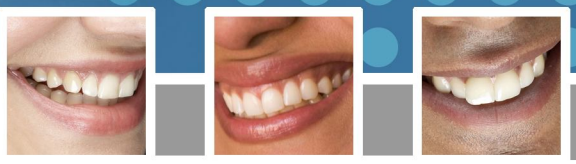

Please indicate if you have any of the following:

- [ ] *Pre-Medication
- [ ] *See Patient Notes
- [ ] Allergy - *See Notes
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Iodine
- [ ] Allergy - Latex
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy-Erythromicin
- [ ] Allergy-Local Anesth
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Contraceptive Use
- [ ] Diabetes
- [ ] Dizziness/Fainting
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Excessive Bruising
- [ ] Gastro-Intestinal
- [ ] Glaucoma
- [ ] Hard To Freeze
- [ ] Hay Fever
- [ ] HBP
- [ ] Head Injury
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis A
- [ ] Hepatitis B
- [ ] Hepatitis C
- [ ] HIV+ (AIDS)
- [ ] Hives
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] LBP
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Multiple Sclerosis
- [ ] Nervous Disorders
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Rheumatoid Arthritis
- [ ] Sinus Problems
- [ ] Skin Rash
- [ ] STD
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] TMJ
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers

Do you have any other health issues or allergies?

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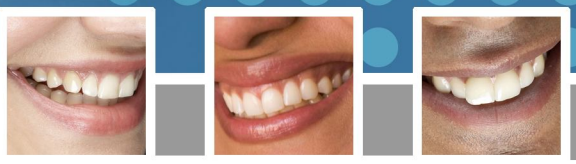

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____