DR. TRUDY NWACHUKWU

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NEW PATIENT INFORMATION/HISTORY/CONSENT FORM

Patient Name…… Date of Birth(mm/dd/yy) ……..

Health card number…….. Insurance Provider……..

Mobile…….. Home phone……..work ……Email……

Address……

1. Within the past year, have there been any changes to your general health ? Yes No
2. What is the date(or approximate date) of your last medical exam?.....
3. Are you currently under the care of a physician due to a specific condition? Yes No
4. Have you been hospitalized within the last 5 years due to surgery or illness? Yes No
5. Are you currently taking any prescription or non-prescription medication? Yes No
6. Are you allergic to (e.g. itching, rash, swelling of hands, feet ,eyes, etc)to any medication? Yes No

Please list your allergies : ……
……

7. WOMEN : Are you pregnant ? Yes No . If yes, when is the due date? ……..
Are you practising birth control? Yes No

8. Circle any of the following that you have experienced:

		Allergy	
COVID-19	Angina	Allergy - aspirin	Allergy –codeine
Allergy –iodine	Allergy -latex	Allergy –penicillin	Allergy – Sulfa
Allergy - erythromycin	Anaemia	Allergy –local anaesthetic	Arthritis
Artificial joints	Asthma	Blood disease	Cancer
Pre-Medication	Diabetes	Dizzines/fainting	Emphysema
Epilepsy	Excessive bleeding	Excessive bruising	Gastro-intestinal
Glaucoma	Hard to freeze	Hay fever	HBP(High blood pressure)
Head Injury	Hearing disabled	Heart disease	Heart murmur
Hepatitis A	Hepatitis B	Hepatitis C	HIV/AIDS
Hives	Jaundice	Kidney Disease	Liver disease
Mental disorders	Multiple sclerosis	Nervousness/anxiety	Pacemaker
Cold Sores	Radiation treatment	Chemotherapy	Respiratory problems
Rheumatic fever	Rheumatism	Rheumatoid arthritis	Sinus problems
STD	Stroke	Stomach ulcer	Sickle cell disease
Thyroid disease	Tuberculosis	Other(please state)……	

9 . Do you smoke ? Yes No
How many years have you been smoking? ..... How many cigarettes do you smoke daily?.....

10. Do you experience shortness of breath, or chest pain with daily activity? Yes No
11. Please list all medications you are currently taking, either prescribed or not:

……
……

12. Do your teeth experience sensitivity to cold or hot temperature? Yes No

13. When was your last visit to the dentist?.....

14. How often do you brush your teeth? .....

15. How frequently do you floss your teeth? .....

16. Do you use mouthwash? Yes No . If yes, name of mouthwash.....

17. Do you clean your teeth with anything else? Yes No If yes, please state.....

18. Do you grind your teeth at night? Yes No

19. Do your gums bleed when you brush/floss? Yes No

20. Who may we thank for referring you to us today? .....

Pharmacy's name..... Address .....

Family Doctor's Name..... Address .....

Dentist Name..... Address.....

I, the undersigned, certify that all of the above medical and dental information is true and accurate to the best of my knowledge. I acknowledge that providing incorrect/inaccurate information has the potential of being hazardous to my health.

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

I consent to the performing of dental/periodontal procedures agreed to be necessary or advisable including the use of local anaesthetics as indicated.

I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of dependents(if any).

I acknowledge that Dr Trudy Nwachukwu PerioCentre and staff have given me no guarantee, warranty or assurance that treatment received from the periodontists or hygienists will be curative and/or successful. I understand that due to individual patient differences, a risk of failure, relapse or worsening of any present dental /periodontal condition may result despite treatment and may require further treatment and/or extraction of teeth. I further acknowledge that I have been advised that in order for me to achieve long term benefits from my treatment, it is required that I perform effective daily oral hygiene including, without limitation, plaque control procedures, and that I regularly attend for cleanings.

I acknowledge that Dr Trudy Nwachukwu PerioCentre is under no obligation to continue to provide services to me and that services can be terminated by the PerioCentre with 7 days notice, either verbally or in writing by the PerioCentre.

I am of lawful age and legally competent to sign this release, or that I have acquired the consent of my parent/guardian, in which case the signature of the parent or guardian below signifies agreement, on behalf of the patient , to all of the above.

Patient / Parent / Guardian Signature Date