Great lakes DENTAL

DR. JENNIFER THOMM

1323 Michigan Ave., Unit B,
Sarnia, ON N7S 4M6

Please take a moment to assist us to getting to know you and your dental needs.

Date: _____ Name: _____

Address: _____ Postal Code: _____

❑ Home Phone: _____ ❑ Cell Phone: _____ ❑ Work Phone: _____
(please check which number you want called first)

Would you like us to confirm your appointments via text message? ❑ Yes ❑ No

Marital Status: _____ Occupation: _____

Date of Birth: _____ Date of last check-up: _____

Referred by: _____

Health Card (OHIP) _____

Email: _____

Insurance Company: _____

Insurance Policy #: _____ ID or cert. # _____

List the medications that you are currently taking (include prescription/non-prescription or blood thinners)

_____

_____

_____

_____

Are you allergic to or have you had any bad reactions to medications? (please list)

_____

_____

_____

_____

Please see other side

Is there any family history of any of the following…

	YES	NO
Diabetes	❑	❑
High Blood Pressure	❑	❑
Bleeding Diseases	❑	❑
Strokes	❑	❑

Have you had any surgical replacements like knee, hip or any fabricated material surgical placed in your body?

_____

_____

_____

	YES	NO
Do you smoke?	❑	❑
(Women) Are you pregnant?	❑	❑
Have you ever had hepatitis or liver disease?	❑	❑
Have you been told that you should not give blood?	❑	❑

	YES	NO
Have you ever had a known exposure to AIDS or HIV?	❑	❑
Have you ever had serious trouble with previous dental treatment?	❑	❑
Have you ever been advised that you require medication before having any dental treatment?	❑	❑

Name of Family Physician: _____

CONSENT: I consent to my physician providing Dr. J.D. Thomm and with any details necessary to complete this medical history that may help to ensure safe dental treatment.

Signature: _____