Dr. Stevo Kozomara D.Sc., B.Dent., M.Sc. Dip Perio, FRCD (C) PERIODONTICS AND IMPLANT DENTISTRY

MEDICAL HISTORY QUESTIONNAIRE

MR. __ MRS. __ MS. __ MISS __ DR.__

NAME: _____

DOB: _____

ADDRESS: _____

_____

CITY: _____POSTAL CODE: _____

PHONE: _____

EMAIL ADDRESS: _____

OCCUPATION: _____

EMPLOYER: _____

WHO REFERRED YOU TO OUR OFFICE:

_____

REASON FOR REFERRAL: _____

_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____

RELATIONSHIP: _____

H#: _____ M#: _____

NAME OF FAMILY DOCTOR: _____

PHONE OR ADDRESS: _____

NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALTY: _____

1ST DENTAL INSURANCE: _____

INSURANCE HOLDER: _____

DOB: _____

GROUP#: _____ CERTIFICATE#: _____

2nd DENTAL INSURANCE: _____

INSURANCE HOLDER: _____

DOB: _____

GROUP# _____CERTIFICATE#: _____

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1. Do you take any medications? __ Yes __ No
   _____
   _____
   _____
   _____
2. Do you smoke, vape or chew tobacco? __Yes __No
   _____
   _____
3. Do you have any allergies? __Yes __No
   _____
   _____
4. Are you pregnant or breastfeeding? __Yes __No
   _____
   _____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT:

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____