Dr. Kevin Gavert, D.D.S., F.R.C.D.(C)
Dentistry Professional Corporation
Oral and Maxillofacial Surgeon

10350 Yonge Street, Suite 304
Richmond Hill, Ontario
L4C 5K9
Phone: 905-770-2323
Fax: 905-770-1967

Medical History Form

Name *(Please Print)*: _____ Phone: ( )_____ HOME

Address: _____Apt. _____ Phone: ( )_____ OTHER

City:_____Postal Code: _____ OHIP #_____

Date of Birth: Day_____Month_____Year_____ Height: _____ Weight:_____

Dentist / Referred by:_____ Students Name of School: _____

Physician: _____ Physician Telephone: _____

Emergency Contact Name: _____Emergency Contact Telephone: _____

Dental Insurance: Carrier: _____ Co-Insurance Carrier: _____

Name of Insured: _____ Name of Insured: _____

Group#: _____ I.D.# _____ Group#: _____ I.D.# _____

D.O.B. of Insured: Day_____Month_____Year_____D.O.B. of Insured: Day_____Month_____Year_____

Employer: _____ Employer: _____

Do you take *ANY* medications? No Yes

List:_____

Are you pregnant (women)? (month: _____) Not Sure No Yes

Do You or Have You Ever Had? (please circle)

Abnormal Bleeding	No	Yes	Jaundice, Hepatitis, Liver Disease	No	Yes
A.S.A or Blood Thinner Therapy	No	Yes	Kidney or Bladder Disease	No	Yes
Anemia or Low Blood Count	No	Yes	Lung Disease	No	Yes
Chest Pains (Heart Angina)	No	Yes	Heart Disease	No	Yes
Asthma / Bronchitis	No	Yes	Ulcer, Colitis, or Bowel Disease	No	Yes
Osteoporosis	No	Yes	Cancer	No	Yes
Seizure Disorder / Epilepsy	No	Yes	Diabetes	No	Yes
Steroid/Cortisone Therapy	No	Yes	Emphysema	No	Yes
Thyroid Condition	No	Yes	High Blood Pressure	No	Yes
Tuberculosis	No	Yes	Positive HIV test	No	Yes
Chemotherapy	No	Yes	Radiation Treatment	No	Yes

Are you well today? Yes No

Do You have any present illnesses? Cold Flu Cough Fever Sore Throat Weakness

(Circle) Dizziness/Fainting Diarrhea Vomiting Weight Loss/Gain

Psychiatric/Mental Health Disorder: Generalized Anxiety OCD Schizophrenia Bipolar
Depression Panic Attacks Addiction/Rehab
Other_____

Any health condition not listed above?_____

Do you have a condition that requires you take antibiotics 1 Hour Before surgery / dental procedures?
Example: Heart Valve Replacement No Yes
Other Surgery: Have you had any operations or been hospitalized for any illness? No Yes

_____

_____

Have you been advised to have a surgery that has not been done? No Yes
Have you ever had any complications with dental extraction? No Yes
Have you ever had any injury, surgery, or radiation to the face, head or neck? No Yes
Have you or a family member ever had a problem with local or general anaesthesia? No Yes
Do You Smoke? No_____ Yes_____ Amount: _____

Do You Drink Alcohol? (Please Circle) Daily Weekly Occasionally Rarely Never

Do you have any ALLERGIES? _____ No Yes

I certify that the above information is correct and complete to the best of my knowledge.
I agree to the release and exchange of dental and medical information between Dr. Kevin Gavert and my physician, dentist, dental insurance carrier or other responsible persons involved in my care and treatment.

Date: _____

Signature: _____

Witness: _____