North End
COMMUNITY
HEALTH CENTRE
Dental Clinic

office: 902.420.0303 ext: 5221
fax: 902.422.0859
dental@nechc.com

CONFIDENTIAL PATIENT RECORD – NECHC DENTAL CLINIC

Chart #:_____ Date: _____

Name: _____ Pronouns: _____ Date of Birth: _____

Name on Health Card/Legal Name: _____ Sex on Health Card: _____

Health Card #: _____ Expiry Date: _____

Address: _____City/Town: _____ Postal Code: _____

Phone #: _____ Alternate #: _____

E-mail: _____

Emergency Contact: _____ Phone #:_____

Relationship to patient:_____

When was your last dental visit? _____ Reason for visit? _____

What is the reason for your visit today? _____

Are you a current patient of the North End Community Health Centre (medical clinic)? Yes_____ No_____

Family doctor: _____ Phone #: _____

Are you on Social Assistance/do you have a case worker? _____

Are you covered by private insurance? _____ If yes, please provide the details:

Name of account holder: _____ Birthdate of Account Holder: _____

Insurance Provider: _____ Account/Certificate #: _____ Group #: _____

Medical History

Do you have, or have you ever had, any of the following? Please check all that apply:

☐ Chest Pain/Angina	☐ Rheumatic Fever	☐ Pacemaker	☐ Steroid Therapy
☐ Osteoporosis	☐ Seizures	☐ Heart Attack	☐ AIDS / HIV
☐ Lung Disease	☐ Diabetes Type 1 / 2	☐ Kidney Disease	☐ Stroke
☐ Heart Murmur	☐ Tuberculosis	☐ Stomach Ulcers	☐ Thyroid Disease
☐ Shortness of Breath	☐ Cancer	☐ Arthritis	☐ Asthma
☐ Sleep Apnea	☐ Acid Reflux	☐ Eating Disorder	☐ Bleeding Issues
☐ Mitral Valve Prolapse	☐ Prosthetic/Artificial Joint	☐ Drug/Alcohol Dependence	☐ Blood Pressure
☐ Neurological Disorder	☐ Mental Health Disorder	☐ Other	

Please provide additional information as needed:

_____

Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? If yes, please list:

_____

_____

Do you have any allergies? If yes, please list: _____

_____

Are you being treated for a medical condition, or have you been treated within the past year? If yes, please explain: _____

_____

Is there any family history of diseases or medical issues? If yes, please explain: _____

_____

Do you have, or have you ever had issues with your heart or blood pressure? If yes, please explain:

_____

Have you ever had hepatitis, jaundice or liver disease? If yes, please explain: _____

_____

Do you have any conditions or are undergoing any therapies that could affect your immune system, such as radiotherapy, chemotherapy, etc.? If yes, please explain: _____

_____

Do you use any recreational drugs, such as cocaine, ecstasy, heroin, opioids, etc.? If yes, please list: _____

What is your level of alcohol consumption? ☐ None ☐ Infrequently ☐ Weekly ☐ Daily

Do you use tobacco products? ☐ Yes / ☐ No

Are you currently breast feeding or pregnant? If pregnant, how many weeks? _____

Are you generally nervous or uncomfortable with dental visits? _____

CONSENT & WAIVER

I hereby give consent to the North End Community Health Centre and Dalhousie Faculty of Dentistry to provide dental treatment.

I understand that treatment is to be performed by licenced practitioners or students under the direct supervision of licenced practitioners.

Information is used in compliance with all applicable federal and provincial privacy legislation, the Nova Scotia Dental Board, College of Dental Hygienists of Nova Scotia and the regulations of Dalhousie University to provide optimal dental care to our patients.

I consent to the use of records which may identify me through the use of photographs or other records that may identify me that have been taken as part of my treatment for continuing education purposes or publication outside of the confines of NECHC for grants and outside donations for the clinic. The purposes include providing these records to individuals who are not involved in my treatment in any way, including during seminars and lectures which involve dental professionals and students who may not be affiliated with NECHC or Dalhousie. This will not happen without prior knowledge

I acknowledge that the North End Community Health Centre Dental Clinic Clinical Primary Care Manager has the authority to discontinue treatment if it has been deemed to be in the best interest of the parties involved, or any reasons deemed necessary. No guarantees or assurances of successful treatment can be made. I understand that the Faculty will make every effort to provide the highest quality of care but there is a risk of failure. I release NECHC and /or Dalhousie University from any legal claims for injury, damage or losses suffered while a patient at the North End Community Health Centre Dental Clinic.

All information given is true and accurate to the best of my knowledge.

_____ _____

Date Patient Signature

_____ _____

Date Witness

Progress Notes

Chart No. | | | | | | | |

Date / Codes Include tooth # & surfaces	Progress Notes (student print and sign entry)	Faculty

Medical Update

Chart No. | | | | | | | |

Date	Med Class (ASA)	Medical Information (student print and sign entry)	Faculty