WELCOME to COMPETITIVE DENTAL HYGIENE CLINIC
OUR PRICES ARE AFFORDABLE!

Mr. _____Mrs._____ Ms. _____ Master_____ Dr._____ ADULT_____ CHILD_____

Name: (Last) _____(First) _____Prefer to be called_____
Date of Birth ___/____/_____ ☐ Male ☐ Female
DD MM YYYY
Address: (Street) _____ (City) _____ON (Postal code)_____
Home phone: (____) _____ Work phone: (____) _____
Cell phone: (___) _____ Fax: (___) _____

Employer/School: _____Occupation: _____
E-mail: _____**Who may we thank for referring you to this office?** _____

Family Physician _____Phone: (___) _____
In case of emergency Notify _____Relation _____ Phone: (___) _____
Person Responsible for the account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other

Primary Insurance
Subscriber: (Name)_____
Relationship: _____Self_____ Spouse_____ Child
Insurance Company:_____
Group # _____Date of Birth ___/____/____
Certificate #_____ DD MM YYYY

Secondary Insurance
Subscriber: (Name)_____
Relationship: _____Self_____ Spouse_____ Child
Insurance Company:_____
Group # _____Date of Birth ___/____/____
Certificate #_____ DD MM YYYY

Health History

Correct answers to the following questions will allow your dentist/dental hygienist to treat you on a more individual basis, providing the care appropriate for your particular needs.
Please answer each question. Check YES or NO. If in doubt, leave blank.

1. Are you in good health now?_____ ☐ **YES** ☐ **NO**
2. Are you under the care of a Physician? _____ ☐ **YES** ☐ **NO**
   If so, what is the condition being treated? _____
3. Have you ever been hospitalized or had a serious illness? _____ ☐ **YES** ☐ **NO**
   If yes, explain _____
4. Have you ever had excessive bleeding after an extraction, or do cuts take a long time to stop bleeding?_____ ☐ **YES** ☐ **NO**
5. Do you use tobacco in any form? If yes, how much? _____ ☐ **YES** ☐ **NO**
6. Do you use alcoholic beverages (more than 2 drinks per day?) _____ ☐ **YES** ☐ **NO**

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any question regarding my medical- dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental hygiene clinic.** I authorize the dental hygienist to perform procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X_____ _____

(Signature) Patient ____Parent _____Guardian_____ (print name of the guardian)

Reviewed by treating Dentist / Dental Hygienist _____**Date**_____

HEALTH HISTORY

Please check **YES** or **NO** to each question, if unsure of a question; please consult with the dentist or dental hygienist.
Do you have or have you ever had any of the following?

GENERAL	**YES**	**NO**
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
Night sweats	☐	☐
Persistent fever	☐	☐
SKIN		
Herpes / Shingles	☐	☐
Rashes / Hives	☐	☐
Changes in skin color	☐	☐
Acne	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
NOSE/THROAT		
Frequent nose bleeds	☐	☐
Sinus problems	☐	☐
Frequent infections	☐	☐
Soreness / hoarseness	☐	☐
Chronic snoring	☐	☐
Sleep Apnea	☐	☐
NERVOUS SYSTEM		
Head / neck injuries	☐	☐
Stroke	☐	☐
Migraines / Headaches	☐	☐
Convulsions /Epilepsy	☐	☐
Numbness / Tingling	☐	☐
Dizziness / fainting	☐	☐
Psychiatric treatment	☐	☐

RESPIRATORY	**YES**	**NO**
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Hay fever / Allergies	☐	☐
Persistent cough	☐	☐
Bronchitis	☐	☐
Cough up of bloody sputum	☐	☐
Difficulty breathing lying down	☐	☐
DIGESTIVE SYSTEM		
Hepatitis A,B,C	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
HEART/BLOOD VESSELS		
Rheumatic (Scarlet) fever	☐	☐
Heart Murmur	☐	☐
Chest pain / discomfort (angina)	☐	☐
Heart attack /trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High / Low blood pressure	☐	☐
Congenital heart disease	☐	☐
Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐

ENDOCRINE	**YES**	**NO**
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition	☐	☐
Other_____	☐	☐
BONE / MUSCLE		
Arthritis/rheumatism	☐	☐
Artificial joints/limbs	☐	☐
URINARY		
Kidney disease	☐	☐
Increase of frequency of urination at night	☐	☐
Bloody urine	☐	☐
BLOOD		
Blood disorder	☐	☐
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusions	☐	☐
OTHER		
Radiation therapy	☐	☐
Chemotherapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
HIV / AIDS	☐	☐
Organ transplant	☐	☐
Sleep disorder	☐	☐
Other_____	☐	☐

Has the CHILD PATIENT recently had?	**YES**	**NO**
Measles	☐	☐
Strep Throat	☐	☐
Mumps	☐	☐
Tonsillitis	☐	☐
Chicken Pox	☐	☐

FOR Women only: Do you suspect you may be pregnant? ☐ **YES** ☐ **NO** **How far?** _____
Are you taking oral contraceptives (birth control) ☐ **YES** ☐ **NO**

Are you allergic to or have you experienced a bad reaction to:

	YES	**NO**		**YES**	**NO**		**YES**	**NO**
Local anesthetic (freezing)	☐	☐	Penicillin / Other antibiotics	☐	☐	LATEX Contact	☐	☐
General anesthetic	☐	☐	Codeine or Aspirin	☐	☐	Other allergies _____	☐	☐
Sedative / Sleeping pills	☐	☐	Sulfa drugs	☐	☐	_____		

Are you currently taking any of the following Drugs? **Name of Medications:**

	YES	**NO**		**YES**	**NO**
Antibiotics	☐	☐	Tranquilizers	☐	☐
Blood Thinners	☐	☐	Insulin / Diabetes drugs	☐	☐
Blood Pressure regulators	☐	☐	Digitalis / Other heart drugs	☐	☐
Thyroid Medicine	☐	☐	Aspirin	☐	☐
Steroids / Cortisone	☐	☐	Nitroglycerine	☐	☐
Antihistamines / Allergy drugs	☐	☐	Recreational drugs	☐	☐
Cold remedies	☐	☐	Other? (Prescription / Non-pres.)	☐	☐

_____
_____

DENTAL HISTORY

Please check YES or NO to each question. If unsure, please consult with the dentist/dental hygienist
Is there any dental problem you would like to treat immediately? ☐ **YES** ☐ **NO**

Do you have or ever had any of the following?

MOUTH / JAWS	**YES**	**NO**
Bleeding or sore gums	☐	☐
Bad breath/ foul odour	☐	☐
Burning lips / tongue	☐	☐
Swelling / lumps in mouth	☐	☐
Frequent blisters, lips / mouth	☐	☐
Cheek or lip biting habit	☐	☐
Clicking / popping jaw joint	☐	☐
Difficulty opening/closing the jaw	☐	☐
Mouth breathing while awake or asleep	☐	☐
Trauma to head / face / neck	☐	☐

TEETH	**YES**	**NO**
Loose teeth	☐	☐
Painful teeth	☐	☐
Sensitivity to cold	☐	☐
Sensitivity to hot	☐	☐
Sensitivity to biting	☐	☐
Sensitivity to sweets	☐	☐
Food catching between the teeth	☐	☐
Clenching or grinding habit / Shifting of teeth	☐	☐
Change in bite / fit of teeth	☐	☐
Oral habits (biting nails, pencils)	☐	☐

Date of last dental visit _____ Date of last dental cleaning?_____
Have you been seeing a Dentist regularly? ☐ **YES** ☐ **NO** Last x-rays?_____
Does dental treatment make you nervous? ☐ **NO** ☐ **Slightly** ☐ **Moderately** ☐ **Extremely**
Are you satisfied with your smile? ☐ **YES** ☐ **NO**
Previous problems with dental treatment? Specify_____

Have you had any of the following?	**YES**	**NO**
Gum surgery	☐	☐
Oral surgery (wisdom teeth, dental implants, bone grafting, jaw joints)	☐	☐
Root canals (Endodontics)	☐	☐
Orthodontics (Braces)	☐	☐
Crowns/Bridges/Dentures	☐	☐
Bite adjustment (selective grinding of teeth) or bite plate appliance	☐	☐

ORAL HYGIENE

Do you use?	**YES**	**NO**	**How often?**
Brush	☐	☐	_____
Dental Floss	☐	☐	_____
Antimicrobial rinse	☐	☐	_____
Fluoride rinse	☐	☐	
Electric brush	☐	☐	
Other	☐	☐	

OFFICE POLICY

Your appointment time will be reserved especially for you. In order to avoid a cancellation fee, please provide our office with 24 hours notice.

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