ConfidentSmiles
Dental Hygiene

The information that is requested on this questionnaire is essential to providing you with the highest standard of care. The protection and privacy of your personal information is important to this office and will only be used for assessment, contact, billing and referral purposes with your permission.

Personal Contact Information

☐ Dr. ☐ Miss ☐ Ms. ☐ Mrs. ☐ Mr. ☐ Other

Name _____
First Initial Last

Address _____ _____ _____
Number Street Apt #

_____ _____ _____
City Province Postal Code

Phone # (_____)_____ (_____)_____ Ext. _____ (____)_____
Home Business Cell

Email address: _____

Preferred method of contact: ☐ Telephone ☐ Home ☐ Work ☐ Cell ☐ Text ☐ E-mail

Date of Birth _____ _____ _____ Age _____
Day Month Year

In case of emergency contact: _____
Name Relationship Number

Financial Information

This information is necessary to process invoices and apply payment

Person responsible for this account: ☐ self ☐ spouse ☐ other

Please complete all information if different from above.

Name _____ Phone (___)_____
First Initial Last

Address _____
Number Street City Province Postal Code

Whom may I thank for referring you? _____

Preferred appointment time? _____

Insurance Information

Employer _____ Insurance Company _____

Subscriber's name _____ DOB _____

Plan # _____ Certificate # _____

Maximum annual coverage? _____

Medical Alert Yes No

Health History

Family Physician _____Street/Phone #_____

Medical Specialist (ie. Chiro/Physio/Massage..)_____

Are you being treated for any medical condition at present or in the last two years? If yes, please explain:
_____

Have you been hospitalized in the last two years? If so, please explain:
_____

Do you have any artificial joints? No Yes Please indicate what/where/when
_____

Have you recently or are presently taking any **prescription, non-prescription** drugs or **herbal** remedies? Please list;
_____, _____, _____
_____, _____, _____

When was your last complete physical examination? _____

Have you ever been advised to take antibiotics before a dental cleaning? □ No □ Yes

Have you ever had an allergic reaction or been advised not to take any medications, ie. **Penicillin, sulfa, ASA, codeine** etc or **latex**). □ No □ Yes Please list;
_____,_____
Do you suffer from seasonal allergies? □ No □ Yes Please list; _____
_____
Do you have any other allergies not listed? (metals etc) _____
Do you suffer from asthma? □ No □ Yes How often do you need medication for relief? _____
Is there a family history of Diabetes, Cancer or Heart Disease? □ No □ Yes
Do you bleed EXCESSIVELY or bruise easily? □ No □ Yes
Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? □ No □ Yes
Do you have any hearing difficulties? □ No □ Yes If yes do you wear any hearing aids? □ No □ Yes
Do you smoke or use any other forms of tobacco? □ No □ Yes

Women: Are you pregnant or suspect you may be? □ No □ Yes Expected due date? _____
Do you take Birth Control Pills or Hormone Supplements? □ No □ Yes
Are you nursing? □ No □ Yes

Please indicate which of the following you presently have or have ever had:

Anemia	Epilepsy/seizures	Hepatitis A B C	Mental health disorder
Angina	Fainting/dizzy spells	Herpes type 1 2	Mitral valve prolapse
Arthritis/rheumatism	High/low blood pressure	Thyroid Disease	Osteoporosis
Artificial heart valves	Heart attack	Organ transplant	Tuberculosis
Cancer	Heart murmur	Hyper/hypo glycemia	Psychiatric treatment
Chemotherapy/radiation	Heart pacemaker	Kidney disease	Scarlet/Rheumatic fever
Crohn's/intestinal/IBS	Heart rhythm disorder	Liver disease	Sinus trouble
Diabetes	Congenital heart defect	Malignant hypothermia	Stomach/ulcers

Do you currently have or have you ever had any disease, condition or problem not listed above?
If so please tell me about it; _____

Dental History

Have you been receiving regular dental care? ☐ No ☐ Yes

Name of Dentist/Dental office _____

Estimated date of your last dental cleaning? _____ X-rays? _____

Have you ever had any of the following? Periodontal treatment (gum treatment or surgery) ☐ No ☐ Yes
Orthodontic treatment (to straighten or re-align teeth) ☐ No ☐ Yes
Night guard or other appliance ☐ No ☐ Yes
Extractions ☐ No ☐ Yes

Have you noticed any growth or sore spots in your mouth? ☐ No ☐ Yes
Any particular area where food catches in between your teeth? ☐ No ☐ Yes
Have you noticed any loose or shifted teeth? ☐ No ☐ Yes
Are any of your teeth sensitive to hot, cold, sweets or pressure? ☐ No ☐ Yes
Do you notice any bleeding when you clean your teeth? ☐ No ☐ Yes ☐ Occasionally
Do you feel you have bad breath? ☐ No ☐ Yes
How often do you brush your teeth? _____ floss _____
Are you presently using a manual or electric toothbrush? _____
Do you use any rinses? ☐ No ☐ Yes If so what brand/type _____ How often? _____
What brand of toothpaste do you usually use? _____
Are you using any other dental aids? (toothpicks, herbal remedies etc) _____
_____
Are you unhappy with the appearance of your teeth? ☐ No ☐ Yes
If so what would you like to see changed? _____

Do you have any emotional concerns about having dental treatment? ☐ No ☐ Yes If yes, please explain;
_____

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 understand that this information will be reviewed at every visit and any changes or additions will be freely, knowingly and duly noted. I authorize the dental hygienist to perform any procedure as may be required to determine necessary treatment. I understand that will give my consent verbally. I have had the opportunity to ask questions and have been advised of the office privacy policy. I understand that the responsibility for payment of the dental services and I assume responsibility for any fees incurred. Please provide two (2) business day notice to cancel or reschedule your appointment. As the relationship between client and dental provider is based on mutual respect a $50. cancellation fee <u>may</u> be applied for a missed appointments or those cancelled without sufficient notice.

X _____ _____ Date_____
Signature Client/Parent/Guardian Name of Parent/Guardian

Reviewed by RDH_____ Date _____