Didsbury Smiles Dental

Date: _____

Legal Full N ame: _____ Male/ Female I like to be called : _____

Home address : _____ City /Province : _____

Postal code / Zip Code: _____ _____ Marital Status: _____ ___ Date of birth (dd/mm/yy): _____

E-mail address: _____

Home phone: _____ ____ Work phone: _____ Cell/ Pager number : _____

Your Employer: _ _____ Occupation: _____

Insurance Co._____ Group#_____ ID#_____ Name_____ DOB_____

2nd Insurance Co. _____ Group#_____ ID#_____ Name_____ _____ DOB_____

How did you hear about us or whom can we thank for referring you? _____

MEDICAL HISTORY

Have you ever had, or been treated for any of the following medical problems? Please circle.

Y N Heart attack/S troke
Y N Hepatitis / Jaundice
Y N Epilepsy /Seizures/F ainting
Y N Ca ncer/C hemotherapy
Y N Psychiatric problems
Y N Tuberculosis
Y N A IDS / HIV
Y N Depression
Y N Anxiety
Y N Liver Disease
Y N Arthritis
Y N Herpes/cold sores

Y N Mitral Valve Prolapse
Y N High /Low Blood P ressure
Y N Abnormal bleeding /Anemia
Y N Kidney problems
Y N Diabetes
Y N Drug/A lcohol abuse
Y N Anemia
Y N Artificial Valves Y N Angina
Y N Congenital Cyanotic Heart defects _____
Y N Surgery: Type &Date:_____ _____
Y N Asthma
Y N Artificial limbs or joints

Have you ever been treated for any other illness not listed above? ___Yes ___ No If yes, please explain :

_____

Are you currently taking prescription medicatio ns, including herbal remedies? If yes, please list below:

_____

Do you have any allergies to any medications or substances ? ___Yes ___ No If yes, please explain:

Have you recently been under the care of a physician? ___Yes ___No If so, for what? _____

Name of physician: _____ Phone #: _____

Last visit with physician: _____ Current Health: ___ Excellent ___ Good ___ Fair ___ Poor

Is there any condition not listed that we should know about? ___Yes ___No If yes, Please explain:_____

DENTAL HISTORY

Why have you come to the dentist today? ___New Patient Exam ___Emergency ___Other Explain:
_____

Date of your last dental visit: _____ Previous Dentist's Name: _____

Do you have any areas of concern? _____

How often do you brush your teeth? _____ Floss? _____ Do your gums bleed? ___Yes ___No

Are your teeth sensitive to ___cold ___sweets ___heat Do your gums feel tender/swollen? ___Yes __No

Do you have bad breath or a bad taste in your mouth? ___Yes ___No

Do you grind/clench your teeth, or notice any clicking/popping noises? ___Yes ___No

Do you wear a night guard? ___Yes ___No Do you suffer from frequent migraines? ___Yes ___No

Do you need to be pre medicated with antibiotics prior to dental treatment? ___Yes ___ No ___

Do you smoke or use chewing tobacco? ___Yes ___ No

Do you snore? ___Yes ___No Do you suffer from Sleep Apnea/ C-pap? ___Yes ___No

Are you interested Cosmetic treatments such as Botox or Juvederm? ___Yes ___No

Women Only: Are you pregnant? _____Yes _____No If yes, how many months? _____

In case of an emergency, is there someone in the area we can call?

Name: _____ Phone #: _____

Relationship to you: _____

I understand that the information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I agree to pay for all services rendered by this dental centre. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission to use any photos taken for lecturing, publishing or educational purposes with my identity removed.

Your appointment time is reserved especially for you. If you are unable to keep this time we ask for 48 hours notice so we may accommodate another patient, otherwise a $50 fee may be charged.

Date: _____ Signature: _____

PRIVACY POLICY

It is our policy to keep all information provided by you confidential. Information you have provided us is used for Diagnostic and billing insurance purposes only. We also collect information in order to know you better. This is to improve both our service to you and your experience with us. We will share and provide information on a need basis to insurance companies, specialists or health care providers as part of the care we provide to you.
Please sign this to acknowledge and accept this privacy policy.

Date: _____ Signature: _____