PROFESSIONAL DENTAL HYGIENE SERVICES

MEDICAL HISTORY

NAME _____ DATE _____

DATE OF BIRTH: _____ MARITAL STATUS _____ OCCUPATION_____

ADDRESS _____

PROVINCE _____ POSTAL CODE _____ PHONE # _____

EMAIL _____

	Yes	No	Not Sure
Are you being treated for any medical condition at present or have you been treated within the last year? If yes, please describe: When was your last medical checkup? _____	◯	◯	◯
Has there been any change in your general health in the last year? If yes, please describe:	◯	◯	◯
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: Medications _____ Latex/Rubber Products _____ Other e.g. hay fever, foods…) _____	◯	◯	◯
Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please describe:	◯	◯	◯
Do you have or have you ever had asthma?	◯	◯	◯
Do you have any heart or blood pressure problems?	◯	◯	◯
Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?	◯	◯	◯
Have you ever had hepatitis, jaundice or liver disease?	◯	◯	◯
Do you have a prosthetic or an artificial joint?	◯	◯	◯
Do you have a bleeding problem or bleeding disorder?	◯	◯	◯

If yes, please describe:			
Have you ever been hospitalized for any illnesses or operations? If yes, please describe:	◯	◯	◯
Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, hepatitis, radiotherapy, chemotherapy? If yes, please describe:	◯	◯	◯

Do you have or have you ever had any of the following?

◯ Alzheimer's	◯ Epilepsy or Seizures	◯ Lung Disease	◯ Steroid Therapy
◯ Angina	◯ Fibromyalgia	◯ Lupus	◯ Stomach Ulcers
◯ Anemia	◯Thyroid Disorder	◯ Migraines	◯ Stroke
◯ Arthritis	◯ Head / Neck Injury	◯ Mitral Valve Prolapse	◯ Thrush
◯ Blood Transfusion	◯ Heart Attack	◯ Osteoporosis Medic'ns (e.g. Fosomax, Actonel)	◯ TMJ Disorder
◯ Cancer	◯ Heart Murmur	◯ Pacemaker	◯ Tuberculosis
◯ Chest Pain	◯ High / Low Blood Pressure	◯ Parkinson's Disease	◯ Sexually Transmitted Diseases
◯ Diabetes	◯ Hodgkin's Disease	◯ Radiation/Chemotherapy	
◯ Drug & Alcohol Dependency	◯ Hypo/Hyperglycemia	◯ Rheumatic Fever	
◯ Emphysema	◯ Kidney Disease	◯ Shortness of Breath	

	Yes	No	Not Sure
Are there any conditions not listed above that you have or have had? If yes, please list:	◯	◯	◯
Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease? If yes, please describe:	◯	◯	◯
Do you smoke or chew tobacco products?	◯	◯	◯
Are you nervous during dental treatment?	◯	◯	◯

Doctor _____Tel # _____

Address _____

GENERAL RELEASE (Please sign after completing medical questionnaire).

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 questions 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 office.** 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.

The information I have provided above is true to the best of my knowledge.

Signature _____ Date _____

PROFESSIONAL DENTAL HYGIENE SERVICES

DENTAL HISTORY

NAME _____ DATE _____

When was your last dental hygiene cleaning? _____

How often did you see your dental hygienist? _____

How many times a day do you brush your teeth? _____ Do you use an electric toothbrush? _____

How often do you floss? _____ How often do you brush your tongue? _____

Do you use a mouthwash? _____How often? _____ What kind? _____

	Yes	No	Not Sure
Do your gums bleed when you brush or floss?	◯	◯	◯
Do you feel you have bad breadth?	◯	◯	◯
Have you ever received instructions about caring for your teeth?	◯	◯	◯
Are there any growths or sore spots in your mouth?	◯	◯	◯
Have you ever been diagnosed with periodontal or gum disease?	◯	◯	◯
Have you ever been advised to take antibiotics before a dental cleaning?	◯	◯	◯
Do you have a dry or burning mouth?	◯	◯	◯
Do you breathe from your mouth when you are awake or asleep?	◯	◯	◯
Do you wear a bruxism appliance?	◯	◯	◯
Have you ever had an allergic reaction to “freezing” (local or topical)?	◯	◯	◯
Have you had prolonged bleeding?	◯	◯	◯
Do you have any dental problems at present (sore gums, sensitivity to hot? cold?) If yes, please describe:	◯	◯	◯
Do you grind or clench your teeth when you are awake or asleep?	◯	◯	◯
Do you have pain in your jaw or joint?	◯	◯	◯
Do you have any additional information or comments you would like to add:			

Patient Consent Form

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the College of Dental Hygienist of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact your for permission to release such information. We may also advise you if such a release in inappropriate. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of those decisions, and the process.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see that Code at any time.

I agree that The Perfect Smile can collect, use, and disclose personal information about _____ *as set out above in the information about the office's privacy policies.*

Signature _____ Print Name _____

Date _____ Signature of Witness _____

the perfect smile

DENTAL INSURANCE INFORMATION

We collect payment upon the date of treatment, submit your insurance on your behalf to the insurance provider, and you will receive re-imbursement from your Insurance company.

We accept Visa, Mastercard, E-transfer or Cheque.

If you or your loved one has insurance, please list the insurance information below.

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder Date of Birth: _____

Insurance Company: _____

Policy Number: _____

Certificate Number/Subscriber ID: _____

<u>If 2nd insurance, please list below:</u>

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder Date of Birth: _____

Insurance Company: _____

Policy Number: _____

Certificate Number/Subscriber ID: _____

Signature:_____ Date: _____