PROFESSIONAL DENTAL HYGIENE SERVICES

MEDICAL HISTORY

PATIENT INFORMATION

NAME _____ DATE _____ DATE OF BIRTH: _____

MARITAL STATUS _____ OCCUPATION_____ PT PHONE #:_____

ADDRESS _____CITY:_____PROVINCE:_____

POSTAL CODE: _____ EMAIL: _____

POA INFORMATION (IF APPLICABLE)

POA PHONE # :_____ RELATIONSHIP TO PATIENT: _____

EMAIL/POA E-MAIL (IF APPLICABLE) _____

	YES	NO	NOT SURE
Are you able to transfer into the dental chair with assistance? If you require a mechanical lift, please advise -> ◯	◯	◯	◯
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 general health/major medical treatments 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: _____	◯	◯	◯
Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please describe: _____	◯	◯	◯
Do you have any heart or blood pressure problems?	◯	◯	◯
Do you have or have you ever had a replacement or repair of a hip, knee, 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 bleeding problem or bleeding disorder? If yes, please describe: _____	◯	◯	◯
Have you ever been hospitalized for any major illnesses or operations? If yes, please describe: _____	◯	◯	◯

	YES	NO	NOT SURE
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 specify:	◯	◯	◯

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

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

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?	◯	◯	◯
Do you use cannabis products (whether for medical or recreational use)? (smoke, vapour, edibles etc.)	◯	◯	◯

Doctor _____Tel # _____

Address _____

the perfect smile

PATIENT CONSENT/GENERAL RELEASE

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 you 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.

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.

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 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 The Perfect Smile 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.
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 _____

PROFESSIONAL DENTAL HYGIENE SERVICES

DENTAL HISTORY

NAME _____ DATE:_____

Last dental hygiene cleaning: _____

How often did you see your dental hygienist? _____

Do you use an electric toothbrush? YES ◯ NO ◯

How many times per day do you brush your teeth?_____

Do you use mouthwash? YES ◯ NO ◯ If yes, what kind?_____

Do you floss your teeth? YES ◯ NO ◯

Do you brush your tongue? YES ◯ NO ◯ If yes, how often?_____

Do you wear any dentures? YES ◯ NO ◯

If yes, please specify: ◯ Complete Upper Denture ◯ Complete Lower Denture

◯ Partial Upper Denture ◯ Partial Lower Denture ◯ Not Sure

	YES	NO	NOT SURE
Do your gums bleed when you brush or floss?	◯	◯	◯
Do you have any growths, sore spots or concerns in your mouth? If yes, please describe_____ _____	◯	◯	◯
Do you wear a bruxism appliance (mouthguard) at night?	◯	◯	◯
Have you ever been advised to take antibiotics prior to a dental cleaning? If yes, please describe: _____	◯	◯	◯
Are you nervous during dental treatment?	◯	◯	◯
Do you breathe through your mouth when you asleep?	◯	◯	◯
Do you wear a C-Pap at night?	◯	◯	◯
Do you grind or clench your teeth when you are awake or asleep?	◯	◯	◯
Have you ever been diagnosed with periodontal or gum disease?	◯	◯	◯
Do you have a bleeding problem or bleeding disorder?	◯	◯	◯
Do you require assistance/help with your oral health maintenance day to day?	◯	◯	◯
Do you have any sensitivity (ie. sensitivity to hot or cold, gum sensitivity)?	◯	◯	◯
Do you suffer from dry mouth?	◯	◯	◯
Have you ever had orthodontic or orthotropic treatment (ie. Braces)?	◯	◯	◯

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: _____

If 2nd insurance, please list below:

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder Date of Birth: _____

Insurance Company: _____

Policy Number: _____

Certificate Number/Subscriber ID: _____

Signature:_____ **Date:** _____