all smiles
DENTAL CENTRE

Patient Information

Name: _____ Todays Date ____ / ____ / ____
First Initial Last D M Y

Address: _____
Box Street Apt City Province Postal Code

Date of Birth: ____ / ____ / ____ Home Ph: _____ Cell Ph: _____
D M Y

Email: _____ Work Ph: _____

Emergency Contact: _____ Ph: _____

Family Physician: _____ Ph: _____

Who may we thank for referring you to this office? _____

Other Family Members that are Patients at All Smiles Dental _____

Financial Information

Person responsible for financial matters: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other
(Please fill out if different from above)

Name: _____
First Initial Last

Address: _____
Box Street Apt City Province Postal Code

Date of Birth: ____ / ____ / ____ Home Tel: _____ Work Tel: _____
D M Y

Email: _____ Cell: _____

Primary Insurance

Insurance Company: _____ Employer: _____

Subscriber: _____ Date of Birth ____ / ____ / ____
First Initial Last D M Y

Group/Policy No: _____ Div/Cert No _____

Secondary Insurance

Insurance Company: _____ Employer: _____

Subscriber: _____ Date of Birth ____ / ____ / ____
First Initial Last D M Y

Group/Policy No: _____ Div/Cert No _____

Patient Health History

(Check all that apply)

Male ☐ Female ☐ *if female,* are you pregnant? ☐ Yes ☐ No

Have you ever had an adverse reaction to:

☐ Local Anesthetics/Novocain ☐ Codeine ☐ Antibiotic _____

☐ Aspirin/Advil ☐ Latex ☐ Other allergies _____

Pharmacy You Use _____ Address _____

Do you take:

☐ Blood thinners (e.g Coumadin, Warfarin Plavix, etc.)

☐ List all medications:

Name of Medication	Dosage	How Often	Condition taken for
eg. Metformin	850mg	1x/day	Diabetes

☐ Additional medications listed on page 4

Have you ever taken *Fosamax (Alendronate), Fosamax Plus D (Alendronate), Actonel (Risedronate), Boniva (Ibandronate), Didronel (Etidronate), Skelid (Tiludronate), IV - Aredia (Pamidronate), IV Bonefors (Clodronate), or IV Zometa (Zoledronic acid)* for any reason? ☐ Yes ☐ No

These above medications are most commonly used for the treatment of Osteoprosis, Pagets Disease and certain Cancer treatments.

Do you have any of the following conditions? ☐ Artificial heart valve ☐ History of infective endocarditis

☐ Cardiac transplant that developed a heart valve problem ☐ Congenital heart condition ☐ Joint replacement

Has your Family Physician recommended you take premedications (antibiotics) before dental treatment? ☐ Yes ☐ No

Other Medical conditions *(Check all that apply)*

☐ Asthma *if yes*, where do you keep your inhaler? _____

☐ Bleeding problems	☐ Epilepsy	☐ Thyroid Disease	☐ Kidney Problems
☐ High Blood Pressure	☐ Tuberculosis	☐ HIV/AIDS	☐ Any Addiction
☐ Breathing Problems	☐ Cancer	☐ Chemo/radiation	☐ Congestive Heart Failure
☐ Psychiatric therapy	☐ Steroid Use	☐ Breathing/COPD	
☐ Change in health in last year	☐ Vertigo	☐ Hepatitis	

Gum Health

The following risk factors make it much easier for periodontal (gum) disease to develop.

Please list all of the risk factors that you have.

☐ Current Tobacco user → What kind _____How much/day For how long _____

☐ Previous Tobacco user → When did you quit _____

☐ Family history of gum disease (parents lost teeth at early age or gum disease on your side of family)

☐ Stress (d*eath of spouse, divorce/separation, death in family, injury/illness, retirement, loss of job, etc.)*

☐ Previous bouts of gum disease or gingivitis

☐ Spouse with gum disease (Gum disease may be transmissible, all family members should be screened for gum disease)

☐ Taking Dilantin, Ca+ Channel Blockers, or Immunosuppressants for organ transplantation

☐ Osteoporosis ☐ Poor nutrition ☐ Lupus Erythematosus ☐ Scleroderma

☐ Diabetes *(additional information requested below)*

Heart Disease Untreated gum disease can increase your risk for heart attack and stroke.	Have you been diagnosed with heart disease/stroke? ☐ Yes ☐ No → Do you have any of these risk factors? ☐ Family history of heart disease ☐ Tobacco use ☐ High cholesterol ☐ High blood pressure
Diabetes Diabetics are more prone to gum disease. Left untreated, gum disease makes it harder for diabetics to control their blood sugar. Diabetics who have their gum disease treated can improve their blood sugar control thus making diabetic complications less likely.	Are you diabetic? ☐ No → Any family history of diabetes? ☒ Yes ☒ No Have any of these warning signs of diabetes? ☐ Frequent urination ☐ Excessive thirst/hunger ☐ Weakness/fatigue ☐ Slow healing of cuts ☐ Unexplained weight loss ☐ Yes → How is your diabetes control? ☐Good ☐Fair ☐Poor Who is your diabetes Doctor _____
Rheumatoid Arthritis If you have rheumatoid arthritis, emerging research suggests that eliminating any gum disease and then keeping it at bay can lessen the crippling effects of arthritis.	Have you ever been diagnosed with Rheumatoid Arthritis? ☐ Yes ☐ No

Dental History

What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other _____
Are you currently having dental pain? ..... ☐ Yes ☐ No
How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Other _____
When was your last dental visit?_____ Last X-Ray? _____

What is your level of anxiety/stress/fear when going to the dentist? ○ None ○ Mild ○ Mod ○ Severe

Please describe your last dental experience: _____

How often do you brush per day?_____ Floss? _____ Use anti-bacterial rinse? _____
Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other_____
Do your gums bleed when: ☐Brushing ☐Flossing ☐Never
Do your gums feel swollen or tender? ..... ☐ Yes ☐ No
Do you have bad breath or a bad taste in your mouth? ..... ☐ Yes ☐ No
Do your jaws crack, pop or grate when you open widely? ..... ☐ Yes ☐ No
Do you grind or clench your teeth? ..... ☐ Yes ☐ No
Do you have food catch between your teeth? ..... ☐ Yes ☐ No
Which of the following are you interested in? ☐ Implants ☐ Crowns or Caps ☐ Full or Partial Dentures
☐ Braces ☐ Gum Treatment ☐ Root Canal Treatment ☐ Extraction
What aspects of your smile would you like to improve?
☐ Crowding/Crooked Teeth ☐ Spaces between teeth ☐ Missing Teeth ☐ Tooth Shape ☐ Dark Teeth
☐ Tooth Size ☐ Teeth are different colors ☐ Other_____
Do you have any other concerns about your teeth or smile? _____

General Release

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ Date _____ /_____/_____

Signature ☐ Self ☐ Parent/Guardian Print Name D M Y

(Medication List continued)

Name of Medication	Dosage	How Often	Condition taken for
eg. Metformin	850mg	1x/day	Diabetes

Credit Card Policy

Office policy requires a credit card to be left on file for the office to accept Assignment (payment) from your insurance carrier. Should there be a remaining balance on your account after receipt of a payment from your insurance carrier, the credit card on file will be charged for the remaining amount.

If you do not wish to leave a credit card on file you will be considered a Non-Assignment account. **As a Non-Assignment account, you will be responsible to pay in full for your dental services on the day of treatment.** We will then assist you in getting reimbursed from your insurance carrier.

Credit Card Disclosure

I, _____, am providing my credit card information to All Smiles Dental Centre. In the event my insurance carrier does not cover the full expense of treatment provided, All Smiles Dental Centre has my permission to bill the difference to my credit card for any amounts owing. A courtesy call will be given for any balances over $100.00

Credit Card # _____

Expiry Date: _____

3 Digit Security Code _____

Signed _____ Date _____

Staff Witness Signature _____ Date _____

Staff Witness Name _____