Smileworx DENTAL

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PATIENT INFORMATION

Name: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr

FIRST: ______________________________ LAST: ______________________________

Preferred Name: ______________________________________ Sex: ☐ M ☐ F

D.O.B. (d/m/y) ________ / ________ / ____________

Address: ____ Apt/Suite: __________

City, Province: ______________________________ Postal Code: ______________________

Occupation: ______________________________ Employer/School: __________________

Phone number:

H: __________________ C: __________________ W: __________________

E-mail: ________________________________

Preferred way to contact you: ☐ Home ☐ Work ☐ Cell ☐ Email

Account responsibility: ________________________ Relationship: ____________________

Whom may we thank for referring you? ____

MEDICAL INFORMATION

Please fill in completely, check answer where applicable.

Physician Name: ______________________________________ Phone: ______________

Date of last phsyical examination: ______________________

Has there been any change in your general health in the past year? Yes No

If yes, please explain:

____

____

Have you ever had an injury, surgery, or radiation therapty to your head, face, jaws or neck? Yes No

Please list all allergies: n/a

____

____

Do you currently, or have you ever had (please check all that apply):

☐ Abnormal blood pressure
☐ Arthritis
☐ Asthma/Bronchitis
☐ Birth control
☐ Bowel disease
☐ Cancer
☐ Chest pain
☐ Chemical/Drug dependancy
☐ Diabetes
☐ Eating disorder
☐ Epilepsy
☐ Food intolerance
☐ Headaches/migraines
☐ Heart disease/damage
☐ Heart murmur
☐ Hepatitis
☐ HIV/AIDS
☐ HPV
☐ Joint replacement
☐ Kidney problems
☐ Liver disease
☐ Pacemaker
☐ Pregnancy - months: _______
☐ Reflux
☐ Sensory Dysfunction (sight/hearing/speech/smell)
☐ Shortness of breath
☐ Stroke
☐ Swelling of ankles
☐ Tendancy to bruise or bleed easily
☐ Ulcers
☐ Thyroid Condition
☐ Any condition not mentioned

Please list medication, prescriptions and over the counter including natural supplements:

____

____

____

____

DENTAL INFORMATION

Former Dentist: ______________________________

When was your last dental exam?

____

Do you have a specific dental concern you would like addressed? Yes ☐ No ☐

If YES, please explain:

____

Do you have any pain in your mouth when you bite? Yes ☐ No ☐

Do your teeth hurt because of hot or cold or sweets? Yes ☐ No ☐

Do you gums bleed when you brush? Yes ☐ No ☐

How often do you brush your teeth? ______ times per day

Do you floss regularly? Yes ☐ No ☐

How often? ______________________________

What cosmetic changes would you like to make to your teeth?

Whiten ☐ Straighten ☐ Improve shape ☐ Other ______________ None ☐

Does food get stuck between any teeth? Yes ☐ No ☐

Do you have any clicking, tightness or pain in your jaw joint? Yes ☐ No ☐

Do you clench or grind your teeth? Yes ☐ No ☐

Are you aware of any bad breath or persistent bad taste in your mouth?

Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

How many, how long ? ______________________________

Do you bite your nails of suck your fingers? Yes ☐ No ☐

Have you ever had local anaesthetic? Yes ☐ No ☐

Have you ever had a bad reaction to anything related to dental treatment?

Yes ☐ No ☐ If yes, please explain:

____

Have you ever had a tooth pulled (including wisdom teeth)? Yes ☐ No ☐

Have you ever had root canal therapy? Yes ☐ No ☐

How nervous are you at the dentist? VERY - 5 4 3 2 1 - NOT AT ALL

ADDITIONAL INFORMATION

Please use this space to elaborate on any responses, or to give any additional information you would like to provide.

____

I understand that the information I have provided is essential to provide the best dental care possible in a safe manner. I acknowledge that all information provided is complete and accurate and will notifty Smileworx Dental immediately if there are any changes.

I have read, understand and acknowledge the Privacy Policy of Smileworx Dental.

I understand that regardless of insurance benefits and coverage, I am responsible for my account and the account for those whom I have indicated responsibility.

I authorize the free exchange of information between Smileworx Dental and my dental insurance agency, including contact information, financial details, extent of coverage, treatment planned and completed.

______________________________ ______________________________

Signature Date

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DENTAL