WELCOME TO OUR OFFICE!

Dr. ◯ Mr. ◯ Mrs. ◯ Miss ◯

Date _____ (Month) _____ (Day) _____ (Year)

Name: _____ (Last) _____ (First) _____ (Initials)

Address: _____ (street) _____ (city) _____ (prov) _____ (postal code)

Date of Birth: _____ (Month) _____ (Day) _____ (Year) Age: _____ Sex: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext. _____ Health card #: _____

Email Address _____

How did you hear about our office? _____

Person responsible for account _____

Relationship to the account holder: self _____ or _____

Primary Insurance Details

Name of Insurance subscriber/holder: _____ **D.O.B.** _____ month/day/year

Address of Insurance subscriber/holder: _____

Employer: _____

Insurance company name: _____

Group policy #: _____ Certificate/ID # _____

Secondary Insurance Details

Name of Insurance subscriber/holder: _____ **D.O.B.** _____

Address of Insurance subscriber/holder: _____

Employer: _____

Insurance company name: _____

Group policy #: _____ Certificate/ID # _____

Is any other member of you family or relative a client at our office _____

I understand I am financially responsible to the dentist for all necessary treatment even if my insurance coverage may not be all inclusive.

I wish to pay each visit as service are performed by: Cash ☐ Debit ☐ Credit card ☐

Date _____ (Month) _____ (Day) _____ (Year)

Signature: _____

Print

Email to: smile@simcoesmiledental.com

Name: Date:

MEDICAL ALERT: PREMEDICATE:

PRESENT PHYSICIAN NAME: PHONE:

SPECIALIST PHYSICIAN NAME: PHONE:

Are you presently under doctor's care? Why?

Have you been under Doctor's care in the past two years? Why?

Have you been hospitalized in the past two year Why?

When was your last complete physical exam?

Have you taken any prescribed, over the counter medications or herbal remedies? ◯Yes ◯No

Are you presently taking any prescribed, over the counter medications or herbal remedies? ◯Yes ◯No

If yes, please list below.

Medication	Dosage	Length of time using this medication

When walking, do you have to stop because of pain in the chest or shortness of breath? ◯Yes ◯No

Have you ever had any types of surgery? ◯Yes ◯No What? _____ When? _____

Are you on special diet? ◯Yes ◯No _____

Have you ever been diagnosed as having tumor or cancer? ◯Yes ◯No _____

Have you ever taken cortisone /steroid medication? ◯Yes ◯No _____

Do you experience problem in healing? ◯Yes ◯No _____

Do you wish to speak privately with the Doctor about any problem? ◯Yes ◯No _____

Do you Smoke? ◯Yes ◯No If yes, how much? _____

Are you currently in good health? ◯Yes ◯No _____

Has any family member had any medical condition? ◯Yes ◯No _____

Allergies

- ☐ Nembutal
- ☐ Ibuprofen (Advil)
- ☐ Demerol
- ☐ Ampicillin
- ☐ Rovamycin
- ☐ Local Anesthetic (freezing)
- ☐ Aspirin
- ☐ Seconal
- ☐ Percodan
- ☐ Erythromycin
- ☐ Cephalexin
- ☐ Nitrous oxide
- ☐ Tylenol
- ☐ Naproxen
- ☐ Darvon
- ☐ clindamycin
- ☐ Sulfa Drugs
- ☐ Valium
- ☐ Tylenol #1, #2, #4
- ☐ Toradol
- ☐ Penicillin
- ☐ Scopalamune
- ☐ Metal
- ☐ chlorhexidine (peridex)
- ☐ 222, 282, 292
- ☐ Codeine
- ☐ Amoxicillin
- ☐ Tetracycline
- ☐ Latex
- ☐ 2food Allergies, please list _____

Please List other Medication or substance which you know you are allergies to: _____

Women only

Are you pregnant? ◯Yes ◯No Due Date: _____

Are you taking birth control pills? ◯Yes ◯No Are you breastfeeding? ◯Yes ◯No

Child patient only (please indicate approximate dates)

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Strep throat
- ☐ Tonsillitis
- ☐ German Measles

Print

Simcoe Smile Dental

Email: smile@simcoesmiledental.com

Name: _____

Medical Conditions: (please check off any of the following conditions you presently have or have had)

- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ congenital heart Lesion
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Anemia
- ☐ Mitral Valve Prolapse
- ☐ Cardiac Arrest/Heart Attack
- ☐ Hypertension
- ☐ Abnormal Bleeding
- ☐ Chest Pain
- ☐ Angina Pectoris
- ☐ Shortness of Breath
- ☐ Swelling of feet/Ankles/Hands
- ☐ Fainting or Dizziness
- ☐ Stroke
- ☐ Diabetes or Hypoglycemia
- ☐ Artificial Joints/Hips
- ☐ Kidney Trouble
- ☐ Ulcers
- ☐ Allergies
- ☐ Cosmetic Surgery
- ☐ Malignant Hyperthermia
- ☐ Tattoos
- ☐ Drug or Alcohol Addiction
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Emphysema
- ☐ Frequent Cough
- ☐ Lung Disease
- ☐ Bronchitis
- ☐ Tuberculosis
- ☐ Liver Disease
- ☐ Hepatitis A (infec)
- ☐ Hepatitis B (serum)
- ☐ Hepatitis C
- ☐ Yellow Jaundice
- ☐ Transdermal nicotine patches
- ☐ Osteoporosis Med (i.e Fosamax)
- ☐ Cancer
- ☐ Thyroid Disease
- ☐ X-ray or Cobalt Tm.
- ☐ Chemo/Radiation
- ☐ Arthritis/Gout
- ☐ Rheumatism
- ☐ Pain in Jaw Joints
- ☐ Cortisone/Steroids
- ☐ Glaucoma
- ☐ Epilepsy or Seizures
- ☐ Glandular Disorder
- ☐ Mental Nervous Disorders
- ☐ Psychiatric Care
- ☐ Bleeding Problems
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ AIDS (HIV Positive)
- ☐ Venereal Disease
- ☐ Cold Sores
- ☐ Fever Blisters
- ☐ Herpes
- ☐ Bruise Easily
- ☐ Sickle Cell Anemia
- ☐ Blood Disorders
- ☐ Circulation Problems
- ☐ Head/Neck Injuries
- ☐ Stomach/Intestinal Problem
- ☐ Eating Disorder

☐ Please list in the detail any other serious illness not shown above which you may have had.

☐ If yes, have you received treatment?
◯ Yes ◯ No

_____

D ental History

Reason for initial visit: _____ Last dental visit: _____

Last Dental Cleaning: _____ Last dental visit: _____

Are you suffering from pain now? Yes☐ No☐
Are your teeth becoming loose? Yes☐ No☐
Have any of your teeth shifted? Yes☐ No☐
Does food get caught between your teeth? Yes☐ No☐
Are any of your teeth sensitive to Yes☐
☐ Cold ☐ Sweet ☐ Biting ☐ Hot ☐ Bitter ☐ pressure
Is there any swelling or pain of your gums? Yes☐ No☐
Do you notice any bleeding from your gums when you brush your teeth, or other? Yes☐ No☐
How often do you brush your teeth?
_____
Do you use dental aids? Yes☐ No☐
Do you use fluoride/mouth rinse? Yes☐ No☐

Jaw Problems: Do you have any of the following:

Clench or grind your teeth while awake or sleep? Yes☐ No☐
Clicking/popping of the jaw when opening or closing? Yes☐ No☐
Pain (in jaw joints-ear,side of the face)? Yes☐ No☐

Difficulty in opening or closing your mouth? Yes☐ No☐
Pain/difficulty in Chewing? Yes☐ No☐
Pain when cleaning your teeth? Yes☐ No☐
Have you had complication from a local anaesthetic? Yes☐ No☐
Have you had any teeth extracted? Yes☐ No☐
any complications? Yes☐ No☐
Do you have burning sensation of the lips, Tongue? Yes☐ No☐
Does your mouth tend to get dry? Yes☐ No☐
Are you aware of bad breath or taste in your mouth? Yes☐ No☐
Are you aware of any sore or growth in your mouth? Yes☐ No☐
Are you nervous to have dental treatment done? Yes☐ No☐
Have you ever had an upsetting experience in a dental office? Yes☐ No☐
Explain: _____

_____

Are you unhappy with the appearance of your teeth? Yes☐ No☐

What would you like to change about your teeth? _____

I certify that i have read, understood and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and i have the chance to ask question and to receive answers regarding the medical and dental histories. As may be required, i consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic procedures and treatment as require to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for dental service provided even if my insurance coverage may not be all inclusive.

☐ Patient ☐ Parent ☐ Guardian Date _____ Signature _____

Print

Email: smile@simcoesmiledental.com

Name: _____

ADDITIONAL MEDICAL INFORMATION

Initial medical history reviewed by: _____ on: _____

MEDICAL UPDATES:

Print

Email: smile@simcoesmiledental.com