Shawnessy Smiles
Dr.Roman Koutsil
647 Shawcliffe Gate SW, Calgary AB T2Y 1W1 P: (403)254-1124 F: (403)453-4615

## Patient Information

Given Name: ______________________Middle Initial: _________Surname:_____________________________________

Gender: M __ F__ DOB: D___/M_____/Y______ Age: _______ Birthplace: __________________________

Address: ____________________________________________________________________________________

City: _____________________ Province: ___________ Postal Code: _______________

Home: ________________________ Cell: _______________________ Bus: _____________________ext.____________

Email for Confirming: ________________________________________________________________________

How did you hear about our office? **Location** ___ **Internet/Website**__ **Other** **(Please Specify)** _____________

**Family/Friend Referral (name)** _____________________________

In case of emergency please call: ________________________________________ Phone: (____)____-_____

Do you have Dental Coverage? **Yes**__ **No** __ **If yes, please provide us with benefits card**

## Dental History

Date of last dental visit (approximate): ______________________ Nature of care received: __________________________

Previous Dental office: ___________________________________________ Phone: _______________________________

Did you have x-rays taken at this time? **Yes** __ **No** __

Do you have any current dental concerns or conditions? ______________________________________________________

Have you experienced an unfavorable reaction from previous dental treatment? **Yes** ___ **No** ___

Do you bruise easily or bleed abnormally following cuts or extractions? **Yes** ___ **No** ___

Have you noticed signs of the following? (**Please check applicable**)

| | | |
|---|---|---|
| **bleeding gums** __ | **bad breath (halitosis)** __ | **sensitivity to cold** __ |
| **swelling of gums** __ | **clicking/popping or pain in jaw**__ | **sensitivity to heat** __ |
| **gum ache** __ | **food collection between teeth** __ | **sensitivity to sweets** __ |
| **receding gums** __ | **grinding or clenching of teeth** __ | **sensitivity when biting** __ |
| **loose teeth** __ | **broken fillings** __ | **Sores / growths in mouth** __ |
| **drifting teeth** __ | **periodontal treatment** __ | |

How often do you floss? ________________________________

How often do you brush? ________________________________

How do you rate yourself as a dental patient? **Calm** __ **Slightly nervous**__ **Very apprehensive** __

## Medical History

Family Physician: ____________________________________________________________ Phone: (____)____-______

Are you currently in good health? **Yes**___ **No**___
If no, please explain________________________________________________________________________________

Are you currently taking any medications, supplements or drugs? **Yes** ___ **No** ___
Pharmacy Name:___________________________________ Phone: (____)____-______
If yes, please list or provide a printout from pharmacy _______________________________________________________

_______________________________________________________________________________________________

Are you allergic to or ever had a reaction to any of the following: **(Please check applicable)**

**Penicillin** ___ **Sulphonamide**___ **Codeine**___ **Aspirin** ___ **Latex**___ **Erythromycin** ___ **Tylenol**___ **Ibuprophine**___

Other: ___________________________________________________________________________________

**** In case of emergency it is important to know if you take: Cialis ___ Viagra ___**

Do you now have or ever had any of the following conditions? **(Please check applicable)**

| | | |
|---|---|---|
| **Aids/HIV positive** ____ | **Headaches** ____ | **Respiratory Disease** ____ |
| **Anemia** ____ | **Heart Conditions** ____ | **Rheumatic Fever** ____ |
| **Arthritis** ____ | **Pacemaker** ____ | **Shortness of Breath** ____ |
| **Artificial heart valve** ____ | **Hemophilia** ____ | **Sinus Trouble** ____ |
| **Asthma** ____ | **Hepatitis, Type** ______ | **Sleep Disorders** ____ |
| **Back Problems** ____ | **High Blood Pressure** ____ | **Snoring** ____ |
| **Blood Disease** ____ | **Joint Replacement** ____ | **Stroke** ____ |
| **Cancer/Tumors** ____ | **Kidney Disease** ____ | **Swelling of feet/ankles** ____ |
| **Chemical Dependency** ____ | **Liver Disease** ____ | **Swollen neck glands** ____ |
| **Chemotherapy/Radiation** ____ | **Low Blood Pressure** ____ | **Thyroid Disease** ____ |
| **Cough up blood** ____ | **Mental Illness** ____ | **Tonsillitis** ____ |
| **Diabetes** ____ | **Mitral Valve Prolapse** ____ | **Tuberculosis** ____ |
| **Emphysema** ____ | **Persistent Cough** ____ | **Ulcer** ____ |
| **Epilepsy** ____ | **Persistent Diarrhea** ____ | **Venereal Disease (STI's)** ____ |
| **Fainting/Dizziness** ____ | **Persistent Skin rash** ____ | |
| **Glaucoma** ____ | **Psychiatric Care** ____ | |

Have you ever had a serious illness or undergone major surgery? **Yes** __ **No**__

If yes, please explain ___________________________________________________________________________

Do you smoke? **Yes** __ **No** __ If yes, how many per day? __________

Women – Are you pregnant? **Yes** __ **No**__ If yes, what is your due date? ________________________________

Is there anything else we should know about your health? **Yes** __ **No** __ If yes, please explain _____________________

_______________________________________________________________________________________________

## Authorization and Release

**I herby certify that the medical and dental histories are accurate and complete to the best of my knowledge. I consent to the performing of the dental oral surgery procedure agreed to be necessary or advisable, including the use of general or local anesthetic or any drugs indicated, and I will assume responsibility for fees associated with those procedures. I also consent to the collection, use, retention and disclosure of personal information as required for my own and my dependants dental care.**

_____________________________________________ _________________________________

**Signature of Patient (or parent/guardian if minor)** **Date**