Shawnessy Smiles

Patient Information

Given Name: ______________________ Middle Initial: _______ Surname: _____________________________________

Gender: M ___ F___ DOB: D_____/M______/Y__________ Age: _______ Preferred Name: ________________

Address: ____

City: _____________________ Province: ___________ Postal Code: _______________

Home: ________________________ Cell: _______________________ Bus: ______________________ext.__________

Email: ____ Appointment Reminder Options: Text ☐ Email ☐ Both ☐

Emergency Contact Name: ________________________________ Relationship: ____________________ Phone: (____) ____-_______

How did you hear about our office? ☐ **Location** ☐ **Internet/Website** ☐ **Community Newsletter** _____________

☐ **Family/Friend Referral (name)** ____________________________ ☐ **Other** **(Please Specify)** _____________

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**
☐ **Swelling of gums**
☐ **Gum ache**
☐ **Receding gums**
☐ **Loose teeth**
☐ **Drifting teeth**

☐ **Bad breath (halitosis)**
☐ **Clicking/popping or pain in jaw**
☐ **Food collection between teeth**
☐ **Grinding or clenching of teeth**
☐ **Broken fillings**
☐ **Periodontal treatment**

☐ **Sensitivity to cold**
☐ **Sensitivity to heat**
☐ **Sensitivity to sweets**
☐ **Sensitivity when biting**
☐ **Sores / growths in mouth**

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/Clinic: ____ 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** ☐ **Ibuprofen**

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, Type?** _________	☐ **Liver Disease**	☐ **Swollen neck glands**
☐ **Chemotherapy/Radiation**	☐ **Low Blood Pressure**	☐ **Thyroid Disease**
☐ **Cough up blood**	☐ **Mental Illness**	☐ **Tonsillitis**
☐ **Diabetes, Type?** ____	☐ **Mitral Valve Prolapse**	☐ **Tuberculosis**
☐ **Emphysema**	☐ **Persistent Cough**	☐ **Ulcer**
☐ **Epilepsy**	☐ **Persistent Diarrhea**	☐ **Venereal Disease (STI's), Type?** _________
☐ **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, vape or use cannabis in any form? **Yes** ☐ **No** ☐ If yes, which one and how often? _________________

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 ___________________________________

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Authorization and Release

I hereby 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**