Patient Information

YONGE Smiles

Family Dentistry | Cosmetic Dentistry | Implant Dentistry

Last	**First**

Preferred Name	

Date of Birth	**Sex**
/ / MONTH DAY YEAR	MALE FEMALE

Home Address			
Street	City	Province	Postal Code

Home Phone	
Work Phone	
Cell Phone	
Email	

In case of emergency whom should we notify?		
Name	Phone	Relation to you

Family Physician	
Name	Phone

Whom may we thank for referring you? _____

How did you hear about our office? _____

Health History

Please Circle **YES** or **NO** to each question. If unsure, please consult with the dentist or hygienist.

1. Are you being treated for any medical condition at present or within the past two years? **YES** **NO**
   If **yes**, please explain: _____

2. Have you recently, or are you presently, taking any Prescription or Non-Prescription drugs? **YES** **NO**
   1) _____ 4) _____
   2) _____ 5) _____
   3) _____ 6) _____

3. Have you ever reacted adversely to any medication or injections? **YES** **NO**
   e.g. Penicillin, Codeine, or any other med.

4. Do you have allergies? **YES** **NO**

5. Do you bleed excessively or bruise easily? **YES** **NO**

6. Do you experience shortness of breath or chest pain when walking or climbing stairs? **YES** **NO**

7. Has a physician ever told you that you have 'heart problems"? **YES** **NO**

8. Do you smoke or use any other forms of tobacco? **YES** **NO**

9. Have you been advised to take antibiotics before a dental appointment? **YES** **NO**

Please indicate if you've ever had the following:

- ○ A.I.D.S
- ○ Anemia
- ○ Angina Pectoris
- ○ Artificial Heart Valve
- ○ Artificial Joint (hip, knee)
- ○ Cancer
- ○ Congenital Heart Lesions
- ○ Diabetes
- ○ Emphysema OR Asthma
- ○ Epilepsy or Seizures
- ○ Fainting or Dizzy Spells
- ○ Glandular Disorders
- ○ Glaucoma
- ○ Heart Disease or Attack
- ○ Heart Murmur
- ○ Heart Rhythm Disorder
- ○ Heart Surgery
- ○ Hepatitis A B C
- ○ High/Low Blood Pressure
- ○ Hypertension
- ○ Jaundice
- ○ Kidney Disease
- ○ Liver Disease
- ○ Lung Disease
- ○ Mitral Valve Prolapse
- ○ Organ Transplant/Medical Implant
- ○ Psychiatric Treatment
- ○ Radiation Treatment/Chemotherapy
- ○ Scarlet Fever » Rheumatic Fever
- ○ Sinus Trouble
- ○ Stomach/Intestinal Problems/Ulcers
- ○ Stroke
- ○ Thyroid Disease
- ○ Tuberculosis

Other: _____

Other: _____

Patient Dental History

1. When was your last dental visit? _____		
2. Was this an emergency visit or a scheduled appointment? _____		
3. Do you have any teeth sensitive to heat, cold, sweets or pressure?	**YES**	**NO**
4. Have you noticed any loose teeth, or shifting of teeth?	**YES**	**NO**
5. Does food catch between your teeth?	**YES**	**NO**
6. Have you ever had gum surgery?	**YES**	**NO**
7. Have you ever had braces?	**YES**	**NO**
8. Are there any details about your previous dental experience, good or bad, that you'd like to discuss with the dentist?	**YES**	**NO**
9. Are you worried or anxious about receiving dental treatment?	**YES**	**NO**
If yes, how do you rate yourself on a scale of 1 to 5 (1= very low, 5 = very high)? _____		
10. Do your gums bleed when you brush or floss?	**YES**	**NO**

Esthetic Evaluation

1. On a scale of 1-10 with 10 being completely satisfied, where do you rank your smile? _____		
2. Would you like to have a whiter smile?	**YES**	**NO**
3. Are there any gaps, chipped or crooked teeth that you would like to discuss with the dentist?	**YES**	**NO**
4. Do you feel that your teeth are too long or too short?	**YES**	**NO**
5. Do you have existing dental work that you consider "Ugly"?	**YES**	**NO**
6. Has anyone ever suggested that you should do something about your teeth or smile?	**YES**	**NO**
7. Do you avoid smiling when having your picture taken?	**YES**	**NO**
8. Would you like for the dentist to discuss ideas about improving your smile?	**YES**	**NO**
9. Do you wish you had a "New Smile"?	**YES**	**NO**
10. Are you missing any teeth, and if so are you interested in replacing them?	**YES**	**NO**

11. What concerns do you have regarding dental treatment? _____

_____

_____

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical–dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

x _____ _____

(signature of patient, parent or guardian) print name of guardian

Reviewed by Treating Dentist: _____ Date: _____