Patient Medical Information

SENSATIONAL SMILES INC.

Friday, March 25, 2022

Title	**First Name**	**Surname**	
Health Card Number		**Email**	
Date of birth	**Occupation**	**Employer**	
Address		**Referred By**	
		Postal Code	
Tel Contact	**Home:**	**Work:**	
	Mobile:		
Emergency Contact		**Emergency Contact Number**	

Are you being treated for any medical conditions at the present time or have been treated within the last year?
Yes ☐ No ☐ Not Sure ☐

If so, why? _____

When was your last medical check-up? _____

Have there been any changes in your general health in the last year?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Do you have any allergies? If you answered yes, please list using the categories below:
Yes ☐ No ☐ Not Sure ☐

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had an uncommon or adverse reaction to any medicines or injections?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have or have you ever had asthma?
Yes ☐ No ☐ Not Sure ☐

_____

Do you have or have you ever had any heart or blood pressure problems?
Yes ☐ No ☐ Not Sure ☐

Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart(i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
Yes ☐ No ☐ Not Sure ☐

Have you ever had hepatitis, jaundice or liver disease?
Yes ☐ No ☐ Not Sure ☐

Which type of hepatitis? _____

Do you have a prosthetic or an artificial joint?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have a bleeding problem or a bleeding disorder?
Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Have you ever been hospitalized for any illness or operations?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

Yes ☐ No ☐ Not Sure ☐

Do you have or have you ever had any of the following? Please Check

☐ AIDS	☐ Digestive Disorders / Acid Reflux	☐ Hypo/Hyperglycemia	☐ Sexually Transmitted Infection
☐ Alzheimers	☐ Drug / Alcohol Dependency	☐ Kidney Disease	☐ Shortness of Breath
☐ Angina	☐ Emphysema	☐ Lung Disease	☐ Sleep Apnea
☐ Anemia	☐ Epilepsy or Seizures	☐ Lupus	☐ Steroid Therapy
☐ Arthritis	☐ Fibromyalgia	☐ Migraine	☐ Stomach Ulcers
☐ Blood Transfusion	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Stroke
☐ Cancer	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Chest Pain	☐ Heart Murmur	☐ Pacemaker	☐ Thyroid Disorder
☐ Cold Sores	☐ High/Low Blood Pressure	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Diabetes Type 1	☐ HIV	☐ Radiation/Chemotherapy	☐ Tuberculosis
☐ Diabetes Type 2	☐ Hodgkins Disease	☐ Rheumatic Fever	

Are there any conditions or disease not listed above that you have or have had?

Yes ☐ No ☐ Not Sure ☐

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Do you smoke or chew tobacco products?

Yes ☐ No ☐ Not Sure ☐

Are you nervous during dental treatment?

Yes ☐ No ☐ Not Sure ☐

If yes, please explain _____

Are you pregnant ?

Yes ☐ No ☐ Not Sure ☐

Hygienist **Tel**

Address

The Information I have given above is true to the best of my knowledge

Patient Signature **Date**

PHIA permits us to collect and use your personal health information. In certain circumstances, PHIA also allows us to share it with others both inside and outside our organization. We do this for purposes such as:

To provide you with health care;

To get payment for your care which could include private insurers;

To do health system planning and research;

To report as required by law;

Unless you tell us not to, we can share your personal health information with any health care provider who has, is or will be providing you with health care. Members of your health care team are only allowed access to the information they need to give you the care you need. If you tell us not to share your information with a health care provider, we will not share your information unless permitted or required by law to do so. Please tell a member of your health care team if you do not want your information shared with a health care provider.

Patient Dental History

SENSATIONAL SMILES INC.

Friday, March 25, 2022

[343.2] Mr. DUNCAN SANDERS

When was your last dental visit? _____

When did you last have dental x-rays taken? _____

How often do you brush your teeth? _____

How often do you floss? _____

	Yes	Don't Know or N/A:	No
Have you been seeing a dentist regularly?	☐	☐	☐
Do any of your teeth ache?	☐	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐	☐
Do your gums bleed when you brush?	☐	☐	☐
Do you have any pain when you chew?	☐	☐	☐
Do you feel that you have bad breath?	☐	☐	☐
Have you ever been in a vehicle accident or experienced any trauma to your jaw?	☐	☐	☐
Have you ever had any implant surgery ?	☐	☐	☐

If you answered yes to the last question, who performed the surgery and when was it done?

_____ Date _____

Are you being followed-up by a dental specialist? _____

Do you have any problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	☐	☐	☐

Is there anything about the appearance of your teeth you would like to change? _____

Please list anything not mentioned above regarding your past dental history:

_____

_____