Healthy Smiles

NEW PATIENT ADULT

Name _____ (LAST / FIRST / MIDDLE INITIAL(S)) AB Health No. _____

Preferred Name _____ Gender _____ Date of Birth M D Y

Address _____ City _____ Postal Code _____

Phone (H) _____ Phone (C) _____ E-mail _____

Employer _____ Occupation _____ Phone (W) _____

In case of emergency, contact _____ Phone _____

WHOM MAY WE THANK FOR YOUR REFERRAL ☐ Friend _____

☐ Google ☐ Radio ☐ Website ☐ Other _____

DENTAL HISTORY

What is your immediate concern? _____

Name of previous dentist _____ Date of last visit _____

I routinely visit the dental office every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely

How often do you brush? _____

How often do you floss? _____

Are your teeth sensitive? ☐ Yes ☐ No

If yes, check all that applies: ☐ Air ☐ Hot ☐ Cold ☐ Sweets ☐ Chewing ☐ Pressure

Does your mouth feel dry or do you have difficulty swallowing? ☐ Yes ☐ No

In the last 5 years, have your teeth changed (become shorter, worn, or shifted place)? ☐ Yes ☐ No

Do you bite your nails, chew ice, chew pens, or have any other habits? ☐ Yes ☐ No

Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ☐ Yes ☐ No

Have you noticed any signs of gum disease (bleeding gums, recession, loose or moving teeth)? ☐ Yes ☐ No

Do you avoid brushing or flossing any part of your mouth because of pain or discomfort? ☐ Yes ☐ No

Do you notice an unpleasant taste or odour in your mouth? ☐ Yes ☐ No

Have you had periodontal surgery (gum graft, pocket reduction surgery, etc.)? ☐ Yes ☐ No

Are you anxious or fearful about dental treatment? ☐ Yes ☐ No

Are you interested in sedation dentistry? ☐ Yes ☐ No

Do you have any concerns about dental treatment? ☐ Yes ☐ No

If yes, please specify _____

Is there anything about the appearance of the teeth or smile that you would like to change? ☐ Yes ☐ No

If yes, please specify _____

Check if you have any of the following:

☐ Previous head, neck, or jaw injury	☐ Migraines or headaches	☐ Stress
☐ Pain or difficulty chewing or yawning	☐ Lock jaw	☐ Snoring
☐ Popping or clicking of jaw joint	☐ Teeth becoming more crowded or overlapped	☐ Sleep apnea
☐ Sore teeth or jaw upon waking up	☐ Difficulty opening jaw wide	☐ Bruxism/night guard
☐ Tired/sore/stiff jaw muscles	☐ Clenching or grinding of teeth	☐ TMJ/splint therapy

MEDICAL HISTORY

Physician's Name _____ Phone _____

Have you been under the care of a medical doctor during the past 2 years? □ Yes □ No
If yes, please explain _____

Have you ever had an allergic or bad reaction to a drug, medication, or other? □ Yes □ No

□ NSAID □ acetaminophen □ codeine □ antibiotic _____
□ latex □ local anesthetic □ sedatives □ other _____

Have you been advised to take antibiotics before undergoing dental procedures? □ Yes □ No

Do you smoke? If yes, please specify including amount _____ □ Yes □ No

Are you dependent on alcohol or drugs? If yes, please specify _____ □ Yes □ No

Check if you have had any of the following, or presently have:

□ Heart disease or attack	□ Stroke	□ Cancer	□ HIV / AIDS
□ Heart surgery	□ Anemia or blood disorder	□ Radiation	□ Venereal disease
□ Congenital heart disease	□ Asthma	□ Chemotherapy	□ Alzheimer's or Dementia
□ Angina	□ Emphysema or COPD	□ Kidney disease	□ Neurological disorders
□ Infective endocarditis	□ Tuberculosis	□ Hepatitis, jaundice, or liver disease	□ Psychiatric care
□ Artificial heart valve	□ Sinus troubles		□ Autism or special needs
□ Pacemaker	□ Diabetes	□ Stomach or digestive problems (e.g. reflux, ulcers, celiac, bulimia)	□ Mental or nervous disorder
□ Artificial joint	□ Thyroid disease		
□ Medical implant	□ Osteoporosis		□ Fainting or dizzy spells
□ High blood pressure	□ Arthritis	□ Glaucoma	□ Epilepsy or seizures
□ Low blood pressure	□ Autoimmune disease	□ Cold sores	

Do you have, or have had, any medical conditions not listed? □ Yes □ No
If yes, please specify _____

Do you have any current medical treatment, impending surgery, genetic/development delay, or other treatment that may affect your dental treatment? □ Yes □ No
If yes, please explain _____

List any current medications, vitamins, and supplements:

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FOR WOMEN Pregnant or trying to become pregnant? □ Yes Nursing? □ Yes Taking birth control? □ Yes

TREATMENT CONSENT

I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. Healthy Smiles may assist with my insurance claims and help provide estimates of costs, but it is my responsibility to understand my dental insurance contract, including coverage and limits. I am responsible for any outstanding amounts owing.

Your appointment times are reserved specially for you. If you are unable to keep your scheduled appointment, **we require a minimum 2 business days notification**. **Short notice cancellations and no shows are subject to a fee of $100.**

Patient Name _____

Signature _____ Date _____

Office Signature _____ Date _____