DENTAL HYGIENE CLINIC

26 Ontario Road
Mitchell, Ontario
N0K 1N0

Provider's use: BP _____ HR _____

CLIENT INFORMATION (CONFIDENTIAL) Today's Date _____

Name: _____ _____ _____ _____
(Surname) (Initial) (First Name) (Preference)

Home Phone: (____)_____ Cell Phone: (____)_____ Work Phone: (____)_____

Address: _____ City: _____ Postal Code: _____

Date of Birth: ____/_____/_____ Age: _____ Sex: _____ Dental Insurance: ☐ Yes ☐ No
D M Y Male/Female

Client's or Parents Employer: _____ Occupation: _____

Spouse or Parent's Name: _____

MEDICAL HISTORY (CONFIDENTIAL)

Physician: _____ Location: _____ Date of Last Exam: _____

Are you being treated for any **medical condition** at the present or have you been treated within the past year?
☐ Yes ☐ No If so, why? _____

Have you ever been hospitalized for any **surgical operation** or **serious illness** within the last 5 years?
☐ Yes ☐ No If yes, please explain _____

Are you taking any **medication(s),** including **herbal or natural supplements**? Please list below.

_____ _____ _____

_____ _____ _____

Have you, or are you receiving **Cancer** treatment or taken any medication for Cancer in the past? ☐ Yes ☐ No

Do you use or have you used **tobacco**? ☐ Yes ☐ No Daily amount? _____ How long? _____

Do you require **pre-medication** before dental treatment? _____

Do you have any **allergies**? ☐ Yes ☐ No

a) Medication
b) Latex/rubber products
c) Other (e.g. hay fever, foods)

_____

Women:

a) Are you pregnant or do you think that you may be pregnant? ☐ Yes ☐ No
b) Are you nursing? ☐ Yes ☐ No
c) Are you taking oral contraceptives? ☐ Yes ☐ No

Do you have or have you had any of the following?

CARDIOVASCULAR
□ Rheumatic fever
□ Heart murmur
□ Heart disease
□ Heart surgery
□ Angina
□ Cardiac pacemaker
□ Heart valve replacement
□ High/Low blood pressure
□ Stroke
□ Heart attack
□ Chest pains
□ Anemia

BLOOD
□ Easily bruise
□ Prolonged bleeding
□ Blood transfusions
□ Blood disorders
□ HIV Positive or AIDS

RESPIRATORY
□ Asthma
□ Bronchitis
□ Sinusitis
□ Tuberculosis
□ Emphysema
□ Other
_____

LIVER
□ Cirrhosis
□ Jaundice
□ Hepatitis
□ Liver Disease

MISC
□ Epilepsy/Convulsions
□ Fainting/Seizures
□ Cancer

JOINTS
□ Arthritis
□ Joint replacement or implant
Date: _____

ENDOCRINE
□ Diabetes
□ Thyroid Problems

GASTROINTESTINAL
□ Ulcers/Stomach trouble
□ Medicine Intolerance

KIDNEY
□ Kidney disease
□ Prostate Cancer

DENTAL HISTORY

What concerns you most about your dental health? _____

Are you having pain at this time? □ Yes □ No If yes, describe where _____

Do you have your teeth cleaned on a routine basis? □ Yes □ No Date of your last dental visit? _____

Have you ever had an upsetting experience in a dental office? □ Yes □ No If yes, describe _____

Have you ever had any of the following;
□ Oral Surgery □ Braces □ Bite Plate/Night Guard □ Dental Implants □ Periodontal (Gum) Surgery

Have you experienced any of the following;
□ Pain or swelling in your gums □ Loosening of your teeth □ Clicking or locking of your jaw
□ Pain in your jaw or jaw joint □ Difficulty opening or closing your mouth □ Bad breath
□ Sore spots or burning sensations in your mouth

How often do you; Brush your teeth _____ Floss _____

Do you have any of the following habits;
□ Clenching or grinding (awake or asleep) □ Hold/bite foreign objects □ Bite your lips/cheeks □ Mouth breathe

AUTHORIZATION AND RELEASE (CONFIDENTIAL)

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dental hygienist to release information regarding my dental treatment to my insurance company and/or when necessary, Physician or Dental Specialist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent to dental treatment by Cherie Gethke's Dental Hygiene Clinic.

I understand that a Registered Dental Hygienist cannot diagnose diseases or conditions, however will refer upon any abnormal findings within the oral cavity. This Independent Dental Hygiene practice does not prescribe or expose xrays.

X_____ Date: _____
Signature of client (or parent if minor)