SMART dental hygiene
Keeping your smile healthy.

Original Date:
MEDICAL ALERT

HEALTH HISTORY FORM

All questions contained in this form are strictly confidential
and will become part of your dental hygiene record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**Date of Birth:**
Address:	
Email Address: Would you like to receive relevant email newsletters/appt reminders? Yes € No €	
Telephone:	**Email:**
Parent or Guardian: ***(if under 18yrs)***	**Language Preferred:** ☐ English ☐ Low German
Emergency Contact Name:	**Emergency Contact Telephone:**
Physician Name:	**Physician Address & Telephone:**
Dentist Name:	**Dentist Address & Telephone:**
INSURANCE #1	

Do you have dental insurance? (benefits)	☐ Yes	☐ No
Insurance Company Name:		
Group # (Plan, Local, or Policy #):		
Insured's Name and Date of Birth:		
Insured's ID #:		
Insured's Employer:		
INSURANCE # 2		
Insurance Company Name:		
Group # (Plan, Local, or Policy #):		
Insured's Name and Date of Birth:		
Insured's ID #:		
Insured's Employer:		

Coverage Details/Notes:

HEALTH HISTORY

Do you consider yourself to be in good health? ☐ Yes ☐ No	**Has there been a change in your health in the last year?** ☐ Yes ☐ No	**Are you being treated for a medical condition?** ☐ Yes ☐ No

Are you taking any medications, inhalers, vitamins or supplements? ☐ Yes ☐ No	**Condition** **Drug**	**Dosage**	**Frequency**

When was your last medical visit?	
Have you had any surgeries?	
Year	Reason
Other hospitalizations:	
Year	Reason

Do you have any allergies? List all: (medications, foods, environment, rubber/latex)	☐ Yes	☐ No
Are you on a special diet?	☐ Yes	☐ No
Do you use tobacco products? What kind:	☐ Yes	☐ No
If yes, are you interested in quitting?	☐ Yes	☐ No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS, DISEASES OR PROBLEMS:

HEART	Cardiovascular disease *(Check all that apply)*: € Heart Trouble/ Heart Attack/ Coronary Insufficiency € High or Low Blood Pressure/ Heart Surgery/ Coronary Occlusion € Heart Murmur/ Irregular Heart Beat/ Coronary Angioplasty/Stent € Mitro Valve Prolapse/ Stroke/ Arteriosclerosis € Congenital Heart Defect/ Congestive Heart Failure/ Rheumatic Fever/ Scarlet Fever € Chest Pain, Angina, Other: _____ € Cardiac Pacemaker € Shortness of Breath/Requires extra Pillows for sleeping at night		
LUNGS	Respiratory conditions such as asthma, tuberculosis, emphysema, persistent cough	☐ Yes	☐ No
BLOOD	Abnormal bleeding, blood disorders/anemia/hemophilia	€ Yes	€ No
	HIV, AIDS or other sexually transmitted infection (chlamydia, gonorrhea, syphilis)	€ Yes	€ No
	Alcohol or drug dependency	€ Yes	€ No
	Herpes (cold sores)	€ Yes	€ No
NERVES	Fainting, dizzy spells	☐ Yes	☐ No
	Psychiatric or mental health condition	☐ Yes	☐ No
	Epilepsy, seizures, or convulsions	☐ Yes	☐ No
ENDOCRINE	Diabetes: Type I or Type II	☐ Yes	☐ No
	Hypoglycemia (low blood sugar)	☐ Yes	☐ No
	Hypothyroid, hyperthyroid, goiter, thyroid removed	☐ Yes	☐ No

BONES, JOINTS & ORGANS	Osteoporosis	☐ Yes	☐ No
	Arthritis or inflammatory rheumatism (painful swollen joints)	☐ Yes	☐ No
	Joint replacement (hip, knee)	☐ Yes	☐ No
	Liver disease, hepatitis, jaundice	☐ Yes	☐ No
	Bladder, kidney problems	☐ Yes	☐ No
	Cancer, radiation, chemotherapy	☐ Yes	☐ No
	Is there any condition not mentioned in this form that should be discussed?	☐ Yes	☐ No
WOMEN ONLY	Currently or possibly pregnant (due date: _____)	☐ Yes	☐ No
	Taking birth control pills or hormone replacement therapy	☐ Yes	☐ No

DENTAL

When was your last dental care visit:		
What was done at this last visit:		
When was your last dental hygiene 'cleaning treatment':		
Have you ever been advised to take antibiotics before dental treatment?	☐ Yes	☐ No
Are there growths or sore spots in your mouth?	☐ Yes	☐ No
Have you ever been diagnosed with periodontal disease or gum disease?	☐ Yes	☐ No
Do you ever have dry or burning mouth?	☐ Yes	☐ No
Have you ever had personalized instruction on caring for your teeth?	☐ Yes	☐ No
Have you ever had an allergic reaction to "freezing" (local anesthetic)?	☐ Yes	☐ No
Do you have difficulty opening your mouth?	☐ Yes	☐ No
Do you have any present dental problems? (sore teeth, sore gums, sensitive teeth, bleeding gums)	☐ Yes	☐ No
Explain:		
Do you have any dentures, partials, crowns, bridges, implants, or other dental appliance?	☐ Yes	☐ No

How often do you brush your teeth: _____	**How often do you floss your teeth:** _____	Is there anything about your smile that you would change? _____

COMMON SERVICES & FEES*

PKG #1 **'Infant & Toddler'** Ages 1-3 yrs **$19** Early and regular happy visits promote less anxiety, less cavities, and could prevent invasive and expensive treatment in the long term. *Up to 15 minutes of time*.*	PKG #2 **'Children & Youth'** Ages 4-13 yrs **$49** Includes complete dental hygiene assessment, risk assessment for oral diseases, dental hygiene diagnosis and proposed treatment plan, one-on-one oral hygiene instruction, tartar/stain removal & application of anticariogenics/antimicrobials (if required, based on individual client need). *Up to 30 minutes of time**	PKG #3 **'Teens & Adults'** Ages 14+ **$99** Includes complete dental hygiene assessment, risk assessment for oral diseases, dental hygiene diagnosis and proposed treatment plan, one-on-one oral hygiene instruction, tartar/stain removal & application of anticariogenics/antimicrobials (if required, based on individual client need). *Up to 60 minutes of time**

PKG #4 ***'Dental Hygiene Exam'*** ***$19*** *Includes complete dental hygiene assessment, risk assessment for oral diseases, dental hygiene diagnosis and proposed treatment plan, impressions for sports guards (if required), eligibility for whitening, evaluation of previous treatment.*	*PKG #5* ***'Dental Sealants'*** First tooth in each quadrant **$19** Additional tooth in each quadrant **$9** *Dental sealants provide extra protection for the grooved and pitted molars by providing a smooth surface to help block food and plaque from getting trapped in small pits and fissures to help prevent tooth decay (cavities).*	*PKG #6* **'In-office Professional Whitening'** **$99.00 + tax** Using IVERI Whitening. No UV, no heat; blue & red LED light enhances whitening using the latest technology. *Requires 'Dental Hygiene Exam' to determine eligibility; which is included in Pkg #3 at no charge. Whitening may not be suitable for everyone.*
PKG #7 ***'Custom Sports Guard or Home Whitening Trays'*** *Coming soon*	PKG #8 **'Mobile Dental Hygiene Services'** For clients with special needs and/or limited mobility. *Coming soon*	**Anesthesia** Non-injection Dental freezing/pain management **$30**

*all treatment is client specific, subject to a maximum amount of time and additional fees. Additional fees as per ODHA fee guide 2014.

Authorization and release:
I certify that I have read and understand the above questions to the best of my knowledge and the above questions have been accurately answered. I understand that providing incorrect or withholding information can be dangerous to my health. I authorize the Dental Hygienist to release any information including the Dental Hygiene diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental Hygiene care to third party payers and/or health practitioners for insurance and health-related referral purposes only. 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 authorize payment directly to the Dental Hygiene office from any group insurance benefits otherwise payable to me. I understand my personal information is collected, used, and stored in a professional and responsible manner according to PIPEDA/PHIPA standards and Smart Dental Hygiene's privacy policy. My dental hygiene services are rendered according to the standards of infection control mandated by the CDHO. I understand that payment is due in full after treatment is rendered (unless prior arrangements have been approved). I give consent for dental hygiene treatment on my behalf (or my dependant) and understand that the specific risks, benefits, and post care instructions will be provided by the dental hygienist during the relevant course of the appointment. Additional written informed consent may be required for complicated or special procedures. I understand that any questions I may have regarding any treatment should be brought forth to be answered and addressed by the dental hygienist.

×_____ Date:_____
Signature of client or parent if minor

OFFICE USE ONLY				
BP:	mm/Hg	LAS/RAS (circle)	Pulse:	BPM
Respirations:		RPM		

Dental Hygienist's Comments:

I have reviewed the above health history;
×_____ Date:_____ Signature of clinician