



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 <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	Date of Birth:
Address:			
Email Address: Would you like to receive relevant email newsletters/appt reminders? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Telephone:	Email:		
Parent or Guardian: <i>(if under 18yrs)</i>	Language Preferred: <input type="checkbox"/> English <input type="checkbox"/> 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)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has there been a change in your health in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you being treated for a medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No																
Are you taking any medications, inhalers, vitamins or supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Condition</th> <th style="width: 40%;">Drug</th> <th style="width: 25%;">Dosage</th> <th style="width: 20%;">Frequency</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Condition	Drug	Dosage	Frequency													
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)		<input type="checkbox"/> Yes <input type="checkbox"/> No																
Are you on a special diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No																
Do you use tobacco products? What kind:		<input type="checkbox"/> Yes <input type="checkbox"/> No																
If yes, are you interested in quitting?		<input type="checkbox"/> Yes <input type="checkbox"/> No																
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS, DISEASES OR PROBLEMS:																		
HEART	Cardiovascular disease (<i>Check all that apply</i>): <input type="checkbox"/> Heart Trouble/ Heart Attack/ Coronary Insufficiency <input type="checkbox"/> High or Low Blood Pressure/ Heart Surgery/ Coronary Occlusion <input type="checkbox"/> Heart Murmur/ Irregular Heart Beat/ Coronary Angioplasty/Stent <input type="checkbox"/> Mitro Valve Prolapse/ Stroke/ Arteriosclerosis <input type="checkbox"/> Congenital Heart Defect/ Congestive Heart Failure/ Rheumatic Fever/ Scarlet Fever <input type="checkbox"/> Chest Pain, Angina, Other: _____ <input type="checkbox"/> Cardiac Pacemaker <input type="checkbox"/> Shortness of Breath/Requires extra Pillows for sleeping at night																	
LUNGS	Respiratory conditions such as asthma, tuberculosis, emphysema, persistent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No																
BLOOD	Abnormal bleeding, blood disorders/anemia/hemophilia	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
	HIV, AIDS or other sexually transmitted infection (chlamydia, gonorrhea, syphilis)	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
	Alcohol or drug dependency	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
	Herpes (cold sores)	<input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
NERVES	Fainting, dizzy spells	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	Psychiatric or mental health condition	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	Epilepsy, seizures, or convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No																
ENDOCRINE	Diabetes: Type I or Type II	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	Hypoglycemia (low blood sugar)	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	Hypothyroid, hyperthyroid, goiter, thyroid removed	<input type="checkbox"/> Yes <input type="checkbox"/> No																

BONES, JOINTS & ORGANS	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Arthritis or inflammatory rheumatism (painful swollen joints)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Joint replacement (hip, knee)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Liver disease, hepatitis, jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Bladder, kidney problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cancer, radiation, chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there any condition not mentioned in this form that should be discussed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
WOMEN ONLY	Currently or possibly pregnant (due date: _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Taking birth control pills or hormone replacement therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there growths or sore spots in your mouth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been diagnosed with periodontal disease or gum disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever have dry or burning mouth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had personalized instruction on caring for your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had an allergic reaction to "freezing" (local anesthetic)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have difficulty opening your mouth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any present dental problems? (sore teeth, sore gums, sensitive teeth, bleeding gums)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Explain:		
Do you have any dentures, partials, crowns, bridges, implants, or other dental appliance?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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*

<p>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. <i>Up to 15 minutes of time*</i>.</p>	<p>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). <i>Up to 30 minutes of time*</i></p>	<p>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). <i>Up to 60 minutes of time*</i></p>
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<p>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.</p>	<p>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).</p>	<p>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.</p>
<p>PKG #7 'Custom Sports Guard or Home Whitening Trays' Coming soon</p>	<p>PKG #8 'Mobile Dental Hygiene Services' For clients with special needs and/or limited mobility. Coming soon</p>	<p>Anesthesia Non-injection Dental freezing/pain management \$30</p>

*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.

x _____ 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;

x _____ Date: _____
Signature of clinician