KOOTENAY SMILE STUDIO

PATIENT HEALTH & DENTAL HISTORY FORM

(Please Print)

PATIENT INFORMATION

Patient's Last name: First:	Birth Date: (YYYY/MM/DD) / /	Age:	Sex: ❑ M ❑ F

Street Address:	City:	Province/State:	Country:

Postal Code:	Home Phone Number:	Cell Phone Number:	Work Phone Number:

E-Mail Address:

PHYSICIAN INFORMATION

Physician's Last name:	First:	Physician's Phone Number:

PRIMARY DENTAL INSURANCE CARRIER

Dental Insurance Carrier:	Group Number:	ID Number:

Subscriber's Name:	Subscriber's Birth Date: (YYYY/MM/DD) / /

Insurance Coverage Details:

A _____ B _____ C _____

Insurance Coverage Limits, If Any:

A _____ B _____ C _____

SECONDARY DENTAL INSURANCE CARRIER (OPTIONAL)

Dental Insurance Carrier:	Group Number:	ID Number:

Subscriber's Name:	Subscriber's Birth Date: (YYYY/MM/DD) / /

Insurance Coverage Details:

A _____ B _____ C _____

Insurance Coverage Limits, If Any:

A _____ B _____ C _____

HEALTH HISTORY

Have you been under the care of a medical doctor over the past two years? ❑ Yes ❑ No	If so, what for?			
Are you taking any medication now, including regular doses of aspirin? ❑ Yes ❑ No	If so, please list Names and Dosages below:			
	1. Name: Dosage:	2. Name: Dosage:	3. Name: Dosage:	4. Name: Dosage:
	5. Name: Dosage:	6. Name: Dosage:	7. Name: Dosage:	8. Name: Dosage:
Are you aware of having any allergic reactions to any medication or substances? ❑ Yes ❑ No	If so, please list below:			
	Allergy 1:	Allergy 2:	Allergy 3:	Allergy 4:
	Allergy 5:	Allergy 6:	Allergy 7:	Allergy 8:

Mark Yes if you have or had any of the following below. Mark No otherwise.

Heart Disease	❑ Yes	❑ No	Psychiatric/Psychological	❑ Yes	❑ No
Heart Attack	❑ Yes	❑ No	Hepatitis A/B/C	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Stroke	❑ Yes	❑ No	Epilepsy/Seizure	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	Artificial Joints	❑ Yes	❑ No
Mitral Valve Prolapse	❑ Yes	❑ No	Radiation/Chemotherapy	❑ Yes	❑ No
Pacemaker	❑ Yes	❑ No	Liver Disease/Jaundice	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Rheumatic/Scarlet Fever	❑ Yes	❑ No
Kidney Problems	❑ Yes	❑ No	Cancer	❑ Yes	❑ No
AIDS/HIV	❑ Yes	❑ No	Bruise Easily	❑ Yes	❑ No
Neurological Disorders	❑ Yes	❑ No	Latex Sensitivity	❑ Yes	❑ No

TMJ AND SLEEP INFORMATION

Mark Yes if you have or had any of the following below. Mark No otherwise.

Headaches (Tension/Migraines)	❑ Yes	❑ No	Sensitive Teeth	❑ Yes	❑ No
Jaw/Joint Pain	❑ Yes	❑ No	Neck Pain	❑ Yes	❑ No
Limited Opening	❑ Yes	❑ No	Difficulty Swallowing	❑ Yes	❑ No
Joint Cracking/Popping	❑ Yes	❑ No	Difficulty Chewing	❑ Yes	❑ No
Congested Ears	❑ Yes	❑ No	Tingling in Arms/Fingers	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No	Insomnia/Frequent Waking	❑ Yes	❑ No
Ringing Ears	❑ Yes	❑ No	Facial Paralysis	❑ Yes	❑ No
Loose Teeth	❑ Yes	❑ No	Back Pain	❑ Yes	❑ No
Posture Problems	❑ Yes	❑ No	Does Floss Shred when you use it?	❑ Yes	❑ No
Clenching	❑ Yes	❑ No	Does Food Catch between your Teeth?	❑ Yes	❑ No
Grinding	❑ Yes	❑ No	Do you have Recession?	❑ Yes	❑ No
Facial Pain	❑ Yes	❑ No	Do your Gums Bleed?	❑ Yes	❑ No

Do you have or have you had any disease, condition or problem not listed? ❑ Yes ❑ No	If so, please describe:		
Women Only:	Are you pregnant?	❑ Yes	❑ No
	Are you nursing?	❑ Yes	❑ No
	Are you taking birth control pills?	❑ Yes	❑ No
What is the reason for your visit today?			
Are you experiencing any pain or discomfort at this time? ❑ Yes ❑ No	If so, please describe:		
Do you feel nervous about dental treatment?		❑ Yes	❑ No
Do you have habits such as clenching, grinding, snoring, or thumb sucking?		❑ Yes	❑ No
Do you or have you seen a chiropractor, massage therapist, or physiotherapist?		❑ Yes	❑ No
Have you ever had Botox treatment?		❑ Yes	❑ No
Have you seen a ENT(ears, nose, and throat specialist)?		❑ Yes	❑ No

CONSENT

From time to time our office will use photographs of our clients for demonstrative purposes. Pictures are used in areas such as this website and/or pictures in the office as part of presentations that we do for other health professionals or clients. Would it be okay to use pictures of you in the future, provided we explain the exact form they would be used in?

❑ Yes ❑ No

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents are due and payable at the time services are rendered unless financial arrangements have been made. If for any reason dental claims are not fully covered by my insurance, I understand that I am responsible for that amount.

❑ I Agree

Signature: _____