fresh DENTAL HYGIENE
206-1139 Sutherland Avenue, Kelowna, B.C., V1Y 5Y2 250 763-7374

PERSONAL INFO

☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Other _____

NAME _____
Last First Middle

ADDRESS _____
Street City Prov/State Postal/Zip

BIRTHDAY _____
Day Month Year

MOBILE #(___) _____ ☐ Preferred Phone HOME # (___) _____ ☐ Preferred Phone WORK #(___) _____ ☐ Preferred Phone

WORK E-MAIL _____ ☐ Preferred E-mail HOME E-MAIL _____ ☐ Preferred E-mail

OCCUPATION _____

MEDICAL HISTORY

- Are you being treated for any medical condition at the present time? Yes ☐ No ☐
- Have you been hospitalized within the last year? Yes ☐ No ☐
- Are you taking any medications, non-prescription drugs or herbal supplements? Yes ☐ No ☐
  If yes, please list:_____reason_____
  _____reason_____
  _____reason_____
  _____reason_____
- Do you have any allergies?
  Medications Latex Iodine Other:
- Do you smoke or chew tobacco products? Y N how many?……/day
- Women: Are you pregnant? Yes ☐ No ☐ When is your due date?……
- Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth or a heart transplant? Yes ☐ No ☐
- Have you ever had hepatitis, jaundice or liver disease? Yes ☐ No ☐
- Do you have a prosthetic or artificial joint? Yes ☐ No ☐
- Have you had cancer? Yes ☐ No ☐ What type? Year:
- Are you on blood thinner medication or do you have bleeding problems?
- Do you have any conditions or therapies that could affect your immune system, ie. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Please list:…….. Yes ☐ No ☐
- How nervous are you during dental treatment on a scale of 1 to 10? (10 being extremely nervous) 1 2 3 4 5 6 7 8 9 10
- Do you have or have you ever had any of the following? Please circle:

Alzheimers	Chest Pains	Drug/Alcohol	Heart Attack	Kidney Disease
Angina	Cold Sores	Dependancy	Heart Murmur	Lung Disease
Anemia	Diabetes (Type 1)	Emphysema	High/Low Blood	Lupus
Arthritis	(Type 2)	Epilepsy or Seizures	Pressure	Migraine
Blood Transfusion	Digestive Disorders/		Hodgkins	Mitral Valve Prolapse
Cancer	Acid Reflux			Osteoporosis

DENTAL HISTORY

- Would you rate your current dental health as: excellent good fair poor
- How frequently do you see a dental hygiene provider? 3month 6month yearly other:
- When was your last teeth cleaning?
- Is there a dental problem you would like taken care of as soon as possible? Y N
- How often do you brush your teeth?
- Is you brush: manual electric
- How often do you floss?
- Are your teeth sensitive to: cold hot sweet sour biting
- Do your gums bleed when: brushing flossing spontaneously
- Have you ever been told that you have periodontal disease or deep gum pockets? Y N
- Is your sugar intake: high medium low
- What is your drink preference: water pop juice milk coffee other:
- Does your mouth feel dry? Y N
- Does your jaw pop or crack when opened widely? Y N
- Do you have dental implants? Y N
- Do you have any bumps, lumps or sore spots in your mouth? Y N
- Do you grind or clench your teeth? Y N
- Do you have any emotional concerns regarding your dental visit?
  fear pain money time constraints embarrassment
- Are you interested in:

improving gum health	orthodontic treatment (braces)
teeth whitening	repairing decayed/chipped teeth
oral hygiene instruction	sport guard or night guard

INFORMED CONSENT AND GENERAL RELEASE

The information I have given above is true to the best of my knowledge. I authorize the dental care provider to perform diagnostic, dental procedures, X-rays, photographs or any other diagnostic aid deemed appropriate and any services necessary. I also assume responsibility for any and all fees associated with these services provided to me or my dependants. I understand that payment is due in full at time of treatment.

APPOINTMENTS:

We operate in an environment of mutual respect. Once you have made an appointment, this time is reserved especially for you; therefore, 48 hour notice must be given if cancellation is necessary.

Patients Signature: Date: