Dr. Lindsay Smith and Associates Family & Cosmetic Dentistry

Patient Code:

Patients last name:_____ First name:_____ Middle:_____

Telephone #:_____ Alternate phone #:_____

Address:_____ City:_____ Postal code:_____

Date of birth:_____ Occupation/employer:_____

In case of emergency contact name and phone #:_____

Email Address:_____ Do you have dental Insurance? Y or N_____

Medical History

Family Physician:_____ Address/Phone #:_____

Are you currently under medical treatment? If so for what?_____

Do you have allergic or unusual reaction to: please circle if yes please explain.

Aspirin	Y or N	_____	Cosmetics	Y or N	_____
Codeine	Y or N	_____	Metals	Y or N	_____
Dental Anaesthetic	Y or N	_____	Other medicines	Y or N	_____
Penicillin	Y or N	_____			

Have you ever been treated for the any of the following:

Aids/HIV	Y or N	Glaucoma	Y or N	Chest Pains	Y or N
Anaemia	Y or N	Hay Fever	Y or N	Persistent Cough	Y or N
Anorexia or Bullmia	Y or N	Heart Condition	Y or N	Rheumatic Fever	Y or N
Arthritis	Y or N	Hemophillia	Y or N	Rheumatold Arthritis	Y or N
Asthma	Y or N	Hepatitis	Y or N	Shortness of Breath	Y or N
Bleeding Problems	Y or N	Liver Disease	Y or N	Seizures	Y or N
Blood Disorders	Y or N	High Blood Pressure	Y or N	Sinus Trouble	Y or N
Bowel Problems	Y or N	Jaundice	Y or N	Stroke	Y or N
Cancer	Y or N	Kidney Problems	Y or N	Thyroid Problem	Y or N
Coughing up blood	Y or N	Leukemia	Y or N	Tuberculosis	Y or N
Diabetes	Y or N	Lung Disease	Y or N	Ulcer	Y or N
Drug or Alcohol	Y or N	Lupus	Y or N	Venereal Disease	Y or N
Emphysema	Y or N	Mitral Valve Prolapse	Y or N	Other	Y or N
Epilepsy	Y or N	Gastrointestinal disorder	Y or N	_____	

1. Have you ever been hospitalized or had a serious illnesss or had any surgery?_____ Y or N_____
2. Are you or have you received any psychiatric care and are you receiving medication for this?_____ Y or N_____
3. Are you being treated for any conditions by a physician in the last two years?_____ Y or N_____
4. Have you had any joint replacements?_____ Y or N_____
5. Do you ever have asthma, hayfever, hives or skin rashes?_____ Y or N_____
6. Do you have any allergies?_____ Y or N_____
7. Have you had any unexplained weight loss, increasing thirst, appetite or urination?_____ Y or N_____
8. Have you ever taken cortisone?_____ Y or N_____
9. Do you have any problems with healing when cut or bruised?_____ Y or N_____
10. Any prolonged bleeding when cut?_____ Y or N_____
11. Have you ever fainted?_____ Y or N_____
12. Are you pregnant or nursing?_____ Y or N_____

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13. Have you taken any drugs, pills, medicines or tablets in the past two years? (please circle)_____ Y or N_____

Antibiotics or sulfa drugs	Cortisone	Insulin or Diabetes drugs	Tranquilizers
Anticoagulants (blood thinners)	Drugs for heart trouble	Nitroglycerin	Water pills
Antidepressants	High blood pressure	Sedatives or sleeping pills	Other_____

14. Have you ever or are you now receiving radiation therapy or chemotherapy?_____ Y or N_____

15. Do you have any in-dwelling catheters?_____ Y or N_____

16.Do you smoke? If so how much?_____/day_____ Y or N_____

17. Is there anything about your medical history that has not been mentioned?_____ Y or N_____

18. Have we missed anything?_____

Dental History

1. When was your last dental Visit?_____

2. How often do you have a dental check up?_____

3. Have you ever had an unfavourable dental experience?_____ Y or N_____

4. Do you have any discomfort in your teeth due to hot or cold, sweets, biting or chewing?_____ Y or N_____

5. Does food catch between your teeth?_____ Y or N_____

6. Do your gums bleed when brushing or flossing?_____ Y or N_____

7. Are you conscious of bad breath or bad taste in your mouth?_____ Y or N_____

8. Do you favour one side when chewing?_____ Y or N_____

9. Are you happy with your smile?_____ Y or N_____

10. If you could, would you change anything about your smile?_____ Y or N_____

11. Do you ever wake up with a headache or have a tired feeling in your face or jaw?_____ Y or N_____

12. Does your jaw pop, click or grate when opening widely?_____ Y or N_____

13. Do you clench or grind your teeth?_____ Y or N_____

14. Have you lost any teeth due to abcess, accident, decay or gum disease? (please circle)_____ Y or N_____

15. Was tooth replacement suggested?_____ Y or N_____

This is to certify that I, the undersigned consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable including the use of local anaesthetic and/or relative analgesia as indicated, and I will assume responsibility for fees associated with those procedures.

_____ _____

Patients (Parent/Guardians) Signature **Date**