Patient Medical Information

Artistic Smiles

Title _____ **First Name** _____ **Surname** _____

Health Card Number _____ **Email** _____

Date of birth _____ **Occupation** _____ **Employer** _____

Address _____ **Referred By** _____

_____ **Postal Code** _____

Tel Contact **Home:** _____ **Work:** _____

Mobile: _____

Emergency Contact _____ **Emergency Contact Number** _____

Are you being treated for any medical conditions at the present time or have been treated within the last year?
☐ Yes ☐ No ☐ Not Sure

If so, why? _____

When was your last medical check-up? _____

Have there been any changes in your general health in the last year?
☐ Yes ☐ No ☐ Not Sure

If yes, please explain _____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
☐ Yes ☐ No ☐ Not Sure

If yes, please list _____

_____

_____

_____

_____

Do you have any allergies? If you answered yes, please list using the categories below:
☐ Yes ☐ No ☐ Not Sure

Medications _____

Latex/Rubber Products _____

Other (e.g. Hayfever, Foods) _____

Have you ever had an uncommon or adverse reaction to any medicines or injections?
☐ Yes ☐ No ☐ Not Sure

If yes, please explain _____

Do you have or have you ever had asthma?
☐ Yes ☐ No ☐ Not Sure

_____

Do you have or have you ever had any heart or blood pressure problems?
☐ Yes ☐ No ☐ Not Sure

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 (i.e. congenital heart disease) or a heart transplant?
☐ Yes ☐ No ☐ Not Sure

Have you ever had hepatitis, jaundice or liver disease?
☐ Yes ☐ No ☐ Not Sure

Which type of hepatitis? _____

Do you have a prosthetic or an artificial joint?
☐ Yes ☐ No ☐ Not Sure

If yes, please explain _____

Do you have a bleeding problem or a bleeding disorder?
☐ Yes ☐ No ☐ Not Sure

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If yes, please explain _____

Have you ever been hospitalized for any illness or operations?

☐ Yes ☐ No ☐ Not Sure

If yes, please explain _____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

☐ Yes ☐ No ☐ Not Sure

Do you have or have you ever had any of the following? Please Check

☐ AIDS	☐ Digestive Disorders / Acid Reflux	☐ Hypo/Hyperglycemia	☐ Sexually Transmitted Infection
☐ Alzheimers	☐ Drug / Alcohol Dependency	☐ Kidney Disease	☐ Shortness of Breath
☐ Angina	☐ Emphysema	☐ Lung Disease	☐ Sleep Apnea
☐ Anemia	☐ Epilepsy or Seizures	☐ Lupus	☐ Steroid Therapy
☐ Arthritis	☐ Fibromyalgia	☐ Migraine	☐ Stomach Ulcers
☐ Blood Transfusion	☐ Head/Neck Injury	☐ Mitral Valve Prolapse	☐ Stroke
☐ Cancer	☐ Heart Attack	☐ Osteoporosis Medications (e.g. Fosamax, Actonel)	☐ Thrush
☐ Chest Pain	☐ Heart Murmur	☐ Pacemaker	☐ Thyroid Disorder
☐ Cold Sores	☐ High/Low Blood Pressure	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Diabetes Type 1	☐ HIV	☐ Radiation/Chemotherapy	☐ Tuberculosis
☐ Diabetes Type 2	☐ Hodgkins Disease	☐ Rheumatic Fever	

Are there any conditions or disease not listed above that you have or have had?

☐ Yes ☐ No ☐ Not Sure

If yes, please list _____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

☐ Yes ☐ No ☐ Not Sure

If yes, please explain _____

Do you smoke or chew tobacco products?

☐ Yes ☐ No ☐ Not Sure

Are you nervous during dental treatment?

☐ Yes ☐ No ☐ Not Sure

If yes, please explain _____

Are you pregnant ?

☐ Yes ☐ No ☐ Not Sure

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HAVE YOU EVER HAD ORTHODONTIC TREATMENT?

DO YOU GRIND OR CLENCH YOUR TEETH? WHEN?

DO YOU STILL HAVE YOUR WISDOM TEETH? IF NOT, WHEN WERE THEY REMOVED?

WHEN WAS YOUR LAST DENTAL CHECK-UP?

WHAT TYPE OF TOOTHBRUSH DO YOU USE? HOW OFTEN DO YOU FLOSS? OTHER CLEANING AIDS?

*****ARE YOU MISSING ANY TEETH OR DO YOU WEAR A FULL OR PARTIAL DENTURE?*****

*****ARE YOU UNHAPPY AT ALL ABOUT THE APPEARANCE OF YOUR TEETH?*****

*****ARE YOU HAVING ANY PROBLEMS WITH CHEWING OR WITH SPEECH?*****

*****DO YOU HAVE A LOT OF FEAR ABOUT GOING TO THE DENTIST?*****

*****DO YOU HAVE A LOT OF DENTISTRY IN YOUR MOUTH NOW?*****

1) ADDITIONAL NOTES:

2) ADDITIONAL NOTES:

HAS THERE BEEN ANY CHANGE TO YOUR MEDICAL HISTORY / INFORMATION SINCE YOUR LAST VISIT?

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ARE YOUR TEETH SENSITIVE TO HOT, COLD OR SWEETS?

ARE YOUR VACCINATIONS UP TO DATE?

NAME OF FAMILY DOCTOR
ADDRESS **PHONE NUMBER**

DO YOU USE ELECTRONIC CIGARETTES OR MARIJUANA PRODUCTS? EXPLAIN.

Dentist **Tel**

Address

The Information I have given above is true to the best of my knowledge

Patient Signature **Date**

PHIA permits us to collect and use your personal health information. In certain circumstances, PHIA also allows us to share it with others both inside and outside our organization. We do this for purposes such as:

To provide you with health care;

To get payment for your care which could include private insurers;

To do health system planning and research;

To report as required by law;

Unless you tell us not to, we can share your personal health information with any health care provider who has, is or will be providing you with health care. Members of your health care team are only allowed access to the information they need to give you the care you need. If you tell us not to share your information with a health care provider, we will not share your information unless permitted or required by law to do so. Please tell a member of your health care team if you do not want your information shared with a health care provider.