Fit Smile
DENTAL HYGIENE

Dental Hygiene Orofacial Myofunctional Therapy	(647) 770-8053	dental@fitsmile.ca

PERSONAL INFORMATION		Date:	
First Name:		Prefered Name:	
Last Name:		Age:	
Address:			
Phone: (H)	(C)	(W)	Email:
Prefered method of contact: Home			
Occupation:			
How did you hear about us?			
Family Doctor:	Phone/Address:	Date of last visit. Reason for visit	
Emergency Contact:	Name:	Relationship:	
	Contact Number:		
FINANCIAL INFORMATION:			
Method of payment: ☐ etransfer ☐ Cash ☐			
Person Responsible for account: ☐ Self ☐ Spouse ☐ Parent/Guardian			
Name of Policy Holder:		Date of Birth:	
Primary Insurance Co Name:			
Group Policy #:		Cert. #:	
Secondary Insurance Co Name:			
Group Policy #:		Cert. #:	

MEDICAL INFORMATION

Are you currently being treated for any medical condition?

If yes, what?

List all the medications you're taking. Prescription, Over-the-counter, herbal supplements.
List DOSAGE of all medications

1.
2.
3.
4.
5.

Do you have any allergies?

Do you smoke or use any other forms?
If so, how many per day? How many years?

Do you drink alcohol? If so, how many drinks per day? Week?

Indicate below any conditions you have or have had. CHECK ALL THAT APPLIES.

☐ Chest Pain ☐ Heart Attack ☐ Stroke, TIA ☐ High/Low Blood Pressure	☐ Lung Disease ☐ Cancer ☐ Tuberculosis ☐ Diabetes ☐ Hepatitis ☐ Pacemaker	☐ Kidney Disease ☐ Arthritis ☐ Thyroid Disease ☐ Anemia ☐ Drug/Alcohol dependency	☐ Rheumatic Fever ☐ Sinus problems ☐ Anxiety ☐ Depression ☐ Herbal Therapy ☐ HIV

Do you have a family history of diabetes? Heart disease? Cancer?

What is your diet like?

☐ Coffee ☐ Tea	☐ Sugar ☐ Soda	☐ Carbonated water	☐ Juice ☐ Fruits

DENTAL HISTORY

Who is your dentist?

Date of your last dental visit. Reason (Check-up, emergency, tooth pain)

How often do you brush your teeth?	How often do you floss?

Have you been told to take antibiotics before a dental appointment?

Do you feel you have bad breath?

Are your teeth sensitive? ☐ No	☐ Hot ☐ Cold	☐ Chewing

Do you snore? Click or tap here to enter text.

Do you have any problems with your jaw? (clicking, limited movement, pain)

Do you wake up with headache, migraine, sore jaw, sore teeth?

Do you feel rested when you wake up in the morning?

Do you have any Dental phobias? Sound, financial burden, anxiety

Do you prefer ___Home visit ___in-studio (Ingersoll)

For Home visit: Arriving at ___House ___Building ___Townhouse

Parking: ___Driveway ___Street ___Visitor's Parking

I understand that this information will be used by Fit Smile Dental Hygiene (Donna Lacsamana) and I consent that the above information is correct.