Sparkling Smiles
DENTAL HYGIENE

Confidential Dental-Medical Questionnaire

Last name: _____ First name: _____ Adult ◯ Child ◯

Gender: _____ Birthdate: ____/____/____ Parent/Guardian(if a child): _____
M D Yr

Address: _____ Apt: _____

City: _____ Province: _____

Postal Code: _____

Cell #: (_____) _____ Other #: (_____) _____

E-mail: _____

Would you like to receive occasional emails with oral health tips and promotions? Yes ◯ No ◯

Occupation: _____Employer: _____

Emergency Contact: _____ Relationship: _____

Phone: (_____) _____

Dental Insurance? Yes ◯ No ◯ Please provide us with your insurance card.

Dentist's name/clinic: _____

How did you hear about us? _____

MEDICAL HISTORY

Family Doctor: _____ Phone: (_____) _____

Do you have any allergies? Please list: _____

Are you presently under a doctor's care for any serious medical issues? ◯ No ◯ Yes

Have you been hospitalized, seriously ill or had surgery? ◯ No ◯ Yes

If yes, when and what for? _____

Are you presently taking any medications? Please list (or provide a list): _____

_____

Have you had a joint replacement? (hip, knee, shoulder etc.) ◯ No ◯ Yes ◯ Unsure

Do you need to take antibiotics before teeth cleaning or dental work? ◯ No ◯ Yes ◯ Unsure

MEDICAL CONDITIONS	No	Yes	Not sure
Mitral Valve Prolapse	◯	◯	◯
Artificial Heart Valve **OR** Heart Valve Repair	◯	◯	◯
Infective Endocarditis	◯	◯	◯
Heart Pacemaker	◯	◯	◯
Heart Murmur	◯	◯	◯
Angina Pectoris/Chest Pain **If yes, do you use nitroglycerin?**	◯	◯	◯
Heart Attack/Cardiac Arrest **When?**	◯	◯	◯
Heart Surgery of Any Kind?	◯	◯	◯
Stroke	◯	◯	◯
High Blood Pressure	◯	◯	◯
Low Blood Pressure	◯	◯	◯
Blood Disorders/Hemophilia/Leukemia	◯	◯	◯
Thyroid disease (hypo/hyper?)	◯	◯	◯
Diabetes **(Type 1 or Type 2?)**	◯	◯	◯
Anemia	◯	◯	◯
AIDS (HIV Positive) Date diagnosed:	◯	◯	◯
Venereal Disease/Sexually Transmitted Infection	◯	◯	◯
Cold Sores/Herpes	◯	◯	◯
COPD/Emphysema/Chronic Bronchitis	◯	◯	◯
Sinus Trouble/Congestion	◯	◯	◯
Sleep Apnea/CPAP Machine	◯	◯	◯
Tuberculosis	◯	◯	◯
Hepatitis A, B, or C/Jaundice	◯	◯	◯
Liver Disease	◯	◯	◯
Kidney Disease	◯	◯	◯
Epilepsy or Seizures	◯	◯	◯
Dizzy/Fainting Spells	◯	◯	◯
Asthma/Shortness of Breath **If yes, do you use puffers? Yes/No** **	◯	◯	◯
Frequent Headaches	◯	◯	◯
Head/Neck/Back Injuries – When?	◯	◯	◯
Cancer **If yes, specify type and date:**	◯	◯	◯
Chemotherapy/Radiation Treatment	◯	◯	◯
Osteoporosis/Bisphosphonate use	◯	◯	◯
Arthritis/Carpel Tunnel	◯	◯	◯
Depression/Anxiety/Nervous Disorders	◯	◯	◯
Rheumatic/Scarlet Fever ** **antibiotics required?**	◯	◯	◯
Artificial Joints (knee, hip etc.) **If yes, when was the surgery?**	◯	◯	◯
Auto-immune disorders? Please specify:	◯	◯	◯

Is there anything else we should know regarding your medical history?

_____

For Women Only:

Are you pregnant or possibly pregnant? ◯ No ◯ Yes

Are you breastfeeding? ◯ No ◯ Yes

DENTAL HISTORY

Are you afraid or anxious of dental treatments? ◯ A little ◯ A lot ◯ Not at all

Last dental checkup (approximately)? _____

Last dental cleaning (approximately)? _____

Are you happy with the appearance of your teeth? _____

Do you have or have you had any of the following?

Orthodontic treatment (Braces) ◯ No ◯ Yes ◯ Unsure

Partial/Complete denture(s) ◯ No ◯ Yes ◯ Unsure

Dental appliance (night guard) ◯ No ◯ Yes ◯ Unsure

Dental implant ◯ No ◯ Yes ◯ Unsure

Crown or bridge ◯ No ◯ Yes ◯ Unsure

Teeth whitening ◯ No ◯ Yes ◯ Unsure

Gum surgery ◯ No ◯ Yes ◯ Unsure

Bleeding gums ◯ No ◯ Yes ◯ Unsure

Sensitive teeth ◯ No ◯ Yes ◯ Unsure

Sensitive gums ◯ No ◯ Yes ◯ Unsure

Burning lips or tongue ◯ No ◯ Yes ◯ Unsure

Dry mouth/Bad breath/Bad taste ◯ No ◯ Yes ◯ Unsure

Locking/Clicking/Pain in the jaw ◯ No ◯ Yes ◯ Unsure

Clench/Grind your teeth ◯ No ◯ Yes ◯ Unsure

Cannabis/CBD oil ◯ No ◯ Yes

Chew tobacco ◯ No ◯ Yes How often? _____

Smoke cigarettes ◯ No ◯ Yes How often/how many? _____
(Now or in the past?)

Vape ◯ No ◯ Yes How often/much? _____

Please read and sign back page.

GENERAL RELEASE (Please read and sign after completing the medical questionnaire)

We require confirmation of all appointments at least **2 business days in advance**. If you fail to confirm your appointment, it will be assumed you no longer require the appointment and will be automatically cancelled.

Our goal is to provide quality preventive dental hygiene care to our clients in a timely manner. No-shows, late arrivals and cancellations negatively affect our clients and staff. We kindly ask that you cancel/reschedule any appointments at least **2 business days in advance.** Failing to show or cancelling/rescheduling an appointment with less than **2 business days notice** will result in a **$50 fee**. If you arrive more than 15 minutes late, we may need to reschedule your appointment. **_____ (initial)**

I promise to inform Sparkling Smiles Dental Hygiene Inc. of any changes to my health and other information provided. I authorize the setting up of my file, its follow-up, as well as my registration on the recall list. I have been informed of my right to consult my file, and that my file will be kept in the practice at all times and only the dental hygienist and auxiliary personnel will have access to it. **_____ (initial)**

I understand that the attending dental hygienist and Sparkling Smiles Dental Hygiene Inc. is not responsible for any previous dental work that may be dislodged, loosened or broken during the course of treatment. I understand that the attending dental hygienist can only visually see potential problems, and dental x-rays (which are taken at a dental office) is the determining factor for possible issues. **_____ (initial)**

You can request your dental office send your x-rays to Sparkling Smiles, or we can request them on your behalf.

I understand that information provided to my medical doctor or other health care providers may be necessary. I understand the office has a privacy policy in place and that my personal information will be collected, used and disclosed within the guidelines of the policy. **_____ (initial)**

I, the undersigned, hereby declare that I have read, understood, and answered the above medical-dental questionnaire to the best of my knowledge. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental information. **_____ (initial)**

I, the undersigned, hereby authorize the indicated treatment necessary or recommended. I assume responsibility for payment of all dental hygiene services rendered for myself and my dependents. **_____ (initial)**

Please consider using debit, cash or etransfer for payments. This helps keep operating costs lower for small business owners as credit card companies charge business owners hefty transaction fees.

X_____ _____

Signature Client/Parent or Guardian Date (M/D/Y)

X_____ _____

Signature of Attending Dental Hygienist Date (M/D/Y)