Welcome to Spearmint Dental

Patient Information

Name _____ Date of Birth __Day__/__Month__/__Year__.

Address _____ Apt# _____ City _____ Postal Code _____

Home Phone # _____ Work Phone # _____ ext _____ Cell Phone # _____

Email Address _____

Person to contact in case of emergency _____ Phone # _____

How did you hear about our office? _____

☐Single ☐Common-Law ☐Married ☐Separated ☐Divorced ☐Widowed ☐Minor _____
(If Minor, Name of Parent or Legal Guardian)

Dental History

Reason for Today's Visit _____

Former Dentist _____City _____ Phone # _____

Date of last dental visit? _____ Date of last dental x-rays? _____

How often do you brush? _____ How often do you floss? _____

Have you had previous Orthodontic treatment? When? _____ Name of Orthodontist _____

Do you have any of the following?

☐ Bad Breath ☐ Food collecting between teeth ☐ Periodontal treatment ☐ Sores or growths in your mouth
☐ Bleeding gums ☐ Grinding/Clenching teeth ☐ Biting Nails/Objects ☐ Sensitivity when biting
☐ Clicking or popping jaw ☐ Loose/broken teeth or fillings ☐ Sensitivity to: ☐Hot ☐Cold ☐Sweets ☐Pressure

Medical History

Physician's Name _____ Phone # _____

Have there been any changes to your health in the past year? If yes, please explain: _____

Have you had any serious illness or operations? If yes, please explain: _____

Have you ever required antibiotics prior to dental treatment in the past? _____

Do you smoke or chew tobacco? If yes, quantity? _____

Are you aware of any adverse reaction to any medications or substances? (Local Anaesthetic (freezing), Penicillin, Erythromycin or other antibiotics, Barbiturates, Sedatives, Analgesics (pain killers), Latex, Other? _____

*****Please turn over and complete*****

List <u>all</u> medications, non-prescription drugs or herbal supplements you are taking:

_____

_____

_____

_____

List all allergies:

_____

_____

_____

_____

_____

Please indicate which of the following you have had or presently have. Please circle yes to any that apply.

Artificial Joints (Knee, Hip, etc)..... Yes
Organ Transplant ..... Yes
Hepatitis A, B or C ..... Yes
Liver Disease ..... Yes
Yellow Jaundice ..... Yes
Heart (surgery, disease, attack) ..... Yes
Chest Pain ..... Yes
Congenital Heart Disease ..... Yes
Heart Murmur ..... Yes
Mitral Valve Prolapse ..... Yes
Artificial Heart Valve ..... Yes
Heart Pacemaker ..... Yes
Rheumatic Fever ..... Yes
High Cholesterol ..... Yes
Fainting or Dizzy Spells ..... Yes
Stroke ..... Yes
High Blood Pressure ..... Yes
Bruise Easily ..... Yes
Blood Disorder (Hemophilia, Anemia, Sick Cell Disease etc) ..... Yes

A.I.D.S ..... . Yes
H.I.V Positive..... . Yes
Venereal Disease ..... Yes
Blood Transfusion ..... Yes
Chemical Dependency ..... Yes
Cold Sores or Fever Blisters ..... Yes
Epilepsy or Seizures ..... Yes
Ulcers ..... Yes
Diabetes ..... Yes
Glaucoma ..... Yes
Cancer ..... Yes
Chemotherapy ..... Yes
Radiation Therapy..... Yes
Emphysema ..... Yes
Chronic Cough ..... Yes
Tuberculosis ..... Yes
Asthma ..... Yes
Hay Fever ..... Yes
Kidney Disease ..... Yes

West Nile Virus ..... Yes
S.A.R.S ..... Yes
Autoimmune Disease (not listed)..... Yes
Infectious Disease (not listed) ..... Yes
Nervous/Anxious ..... Yes
Psychiatric/Psychological Care ..... Yes
Neurological Disorder ..... Yes
Arthritis/Rheumatism ..... Yes
Osteoporosis ..... Yes
Thyroid Problems ..... Yes
Sinus Trouble ..... Yes
Celiac Disease ..... Yes
Cortisone Treatment ..... Yes
Latex Sensitivity ..... Yes
Women Only : Are you pregnant .... Yes
Women Only : Birth Control ..... Yes
Women Only : Nursing ..... Yes
Other (Not listed above):_____
_____
_____

Office Policy

Our office accepts direct payment from your dental insurance for the services which your plan covers. This service is only available to accounts that are kept current. You are responsible for providing the necessary information required for us to direct bill your insurance company, as well as informing us of any changes to this information. If your dental plan does not cover the full cost of your treatment, you will be responsible for any differences between the amount paid by your plan and the amount charged at the time of service, unless other financial arrangements have been previously arranged. Accounts that are not paid within 90 days will be sent to an outside collection agency and your account will be closed.

Once you have booked an appointment, this time is reserved especially for you; therefore, if you are unable to keep the appointment we require **at least 48 hours, (2 business days notice).** There will be a charge for missed or cancelled appointments where **48 hours, (2 business days notice)** is not given. Patients who miss 2 appointments without the proper notice within a 12-month period will not be allowed to schedule future appointments with our office.

I certify that I have read and understand the above information, and I consent to all dental procedures required, including the use of local anaesthetics. I also agree to respect all policies of this office in regards to accounts and cancellations of appointments.

Patient (or Legal Guardian) Signature: _____ Date: _____

OFFICE USE ONLY – MEDICAL UPDATE

Date	Comments	Initials	Date	Comments	Initials