ONsite dental hygiene

Patient Contact and Insurance Information

Please fill out a separate form for each patient.

PERSONAL INFORMATION

First Name:_____
Preferred Name:_____
Last Name:_____
Address 1:_____
Address 2:_____
City:_____
Province:_____
Postal Code:_____
Gender:_____
Date of Birth (mm/dd/yyyy):_____
Email:_____
Phone (Cell):_____ Phone (Home):_____ Phone (Work):_____
Preferred Method of Communication (Circle all that apply): Email Text Phone
Emergency Contact
Number:_____
Would You Like Essential Oils Diffused During Your Appointment? Yes ☐ No ☐

Lavender (Circle all that apply)
Lemon
Peppermint
Lemongrass

INSURANCE INFORMATION

Company Name:_____
Policy Number:_____
Division Number:_____
Subscriber ID:_____
Dependent Code:_____
Relationship (Circle one): Policyholder Dependent

DENTAL HISTORY

When was your last dental visit?_____
When did you last have x-rays taken?_____
How often do you brush your teeth?_____
How often do you floss?_____

	YES	NO	DO NOT KNOW or N/A
Have you been seeing a dentist regularly?	☐	☐	☐
Do any of your teeth ache?	☐	☐	☐
Do your gums bleed when you brush?	☐	☐	☐
Do you have any pain when you chew?	☐	☐	☐
Do you feel that you have bad breath?	☐	☐	☐
Do you suffer from dry mouth?	☐	☐	☐
Are you a mouth breather at night?	☐	☐	☐
Do you have any problems with your jaw (pain, sounds, limited opening, locking, popping)?	☐	☐	☐
Have you ever had dental implants?	☐	☐	☐

If yes, who performed the surgery and when?_____ Date (mm/yyyy):_____
Are you being followed by a dental specialist?_____
Is there anything about the appearance of your teeth that you would like to change?_____
_____
Please list anything not mentioned above regarding your past dental history that you feel we should know:_____
_____
_____

MEDICAL HISTORY

Are you being treated for any medical conditions at the present time or have been treated within the last year?_____
When was your last medical check-up (mm/yyyy):_____
Have there been any changes in your general health in the last year?_____
_____
Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes ☐ No ☐
Please list: Medication/supplement name Reason for use

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any allergies? Yes ☐ No ☐ Not Sure ☐
If you answered yes, please list using the categories below:
Medications:_____
Latex/Rubber Products:_____
Other (e.g. Hayfever, Foods):_____

Have you ever had an uncommon or adverse reaction to any medicine or injections? Yes ☐ No ☐
Not Sure ☐
If yes, please explain:_____

Do you have or have you ever had asthma? Yes ☐ No ☐ Not Sure ☐
Type of puffer:_____

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

Do you have or have you 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 (any kind), 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 ☐

If yes, please explain:_____

Have you ever been hospitalized for any illnesses 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, HIV infection/AIDS, radiotherapy, chemotherapy) Yes ☐ No ☐ Not Sure ☐

If yes, please explain:_____

Do you have or have you ever had any of the following? Please check all that apply:

☐ Alzheimers	☐ Drug/Alcohol Dependency	☐ Lung Disease	☐ Sleep Apnea
☐ Anemia	☐ Emphysema	☐ Lupus	☐ Steroid Therapy
☐ Angina	☐ Epilepsy/Seizures	☐ Migraines	☐ Stomach Ulcers
☐ Arthritis	☐ Fibromyalgia	☐ Mitral Valve Prolapse	☐ Stroke
☐ Blood Transfusion	☐ Head/Neck Injury	☐ Osteoporosis meds	☐ Thrush
☐ Cancer	☐ Heart Attack	☐ Pacemaker	☐ Thyroid Disorder
☐ Chest Pain	☐ Heart Murmur	☐ Parkinsons Disease	☐ TMJ Disorder
☐ Cold Sores	☐ High/Low Blood Pressure	☐ Radiation/Chemo	☐ Tuberculosis (TB)
☐ Diabetes Type I	☐ Hodgkins Disease	☐ Rheumatic Fever	
☐ Diabetes Type II	☐ Hypo/Hyperglycemia	☐ Sexually Transmitted Infection	
☐ Digestive Disorders	☐ Kidney Disease	☐ Shortness of Breath	

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

Yes ☐ No ☐ Not Sure ☐

If yes, please explain:_____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, heart disease) Yes ☐ No ☐ Not Sure ☐

If yes, please explain:_____

Do you smoke or chew tobacco products? Yes ☐ No ☐ Not Sure ☐

Do you vape? Yes ☐ No ☐

Do you use cannabis products? Yes ☐ No ☐

If so, please tell us how:_____

Are you nervous during dental treatment? Yes ☐ No ☐ Not Sure ☐