We are pleased to welcome you to our office. Please take a few minutes to fill out these forms as completely as you can. If you have any questions, we’ll be glad to help you.

Personal Information

❏ Mr. ❏ Mrs. ❏ Ms. ❏ Miss

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name

Middle Name Preferred Name

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Unit #\_\_\_\_\_\_\_ City Postal Code

Phone (H) (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_ Cell (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Sex ❏ Male ❏ Female

Occupation: Parent/Guardian Name

Family Doctor Name Phone

Dentist Name Phone

Emergency Contact Name Phone

How did you hear about us? ❏Google ❏Facebook ❏Bus ❏Mail ❏Drive By ❏Friends/Family

 ❏Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Policy 1 Information

Your relationship to Subscriber ❏ Self ❏ Spouse ❏ Child ❏ Other

Subscriber Full Name

Subscriber Birthdate Subscriber Phone (\_\_\_)

Subscriber Address

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company

Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Certificate/Subscriber ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Policy 2 Information

Your relationship to Subscriber ❏ Self ❏ Spouse ❏ Child ❏ Other

Subscriber Full Name

Subscriber Birthdate Subscriber Phone (\_\_\_)

Subscriber Address

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company

Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Certificate/Subscriber ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to Email and/or Text Message

Patients in our office may be contacted via email and/or text message to remind you of an appointment, to obtain feedback on your experience, and to provide general health reminders/information.

 \_\_\_\_\_ (Patient initials) I consent to receive text messages at my cell phone and any number forwarded or transferred to that number.

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (\_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ (Patient initials) I consent to emails, to receive communications as stated above. The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Patients Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Health History

Are you in good general health? ❏ Yes ❏ No

Would you say your diet is adequate and balanced? ❏ Yes ❏ No

Do you wear contact lenses? ❏ Yes ❏ No

Do you smoke? ❏ Yes ❏ No If yes, how many per day? \_\_\_\_\_ Years smoked? \_\_\_\_

Are you interested in taking part in a smoking cessation program? ❏ Yes ❏ No

Do you consume alcohol? ❏ Yes ❏ No If yes, how many drinks per day \_\_\_\_/week\_\_\_\_

Are you taking / do you take recreational drugs? ❏ Yes ❏ No

Are you allergic to any medications, foods, drugs, metals, latex? ❏ Yes ❏ No Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest

constriction? ❏ Yes ❏ No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated for any medical condition at present or within the past two years? ❏ Yes ❏ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized in the past two years? ❏ Yes ❏ No If yes, please explain

Do you have a prosthetic or artificial joint? ❏ Yes ❏ No

Do you bleed over 5 minutes when cut? Do you bruise easily? ❏ Yes ❏ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any hearing difficulties? ❏ Yes ❏ No If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women: Are you Pregnant? ❏ Yes ❏ No Do you take Birth Control Pills? ❏ Yes ❏ No

Do you take a hormone supplement? ❏ Yes ❏ No

Indicate which of the following you presently have or have ever had: (Check all that apply)

❏ Chest Pain

❏ Heart Attack Date:

❏ Stroke

❏ Mitral Valve Prolapse

❏ High/low Blood Pressure

❏ Pacemaker

❏ Shortness of Breath

❏ Lung Disease

❏ Tuberculosis

❏ Cancer Type: Date:

❏ Steroid Therapy

❏ Diabetes ❏ Type I ❏ Type II

❏ Hepatitis ❏ A ❏ B ❏ C

❏ Stomach Ulcer

❏ Arthritis

❏ Seizures

❏ Kidney Disease

❏ High Cholesterol

❏ Hormone Therapy

❏ Anxiety

❏ Depression

❏ Herbal Therapy

❏ Anorexia/Bulimia

❏ Anemia

❏ HIV

❏ Thyroid Disease

❏ Diet Pill Therapy

❏ Drug/Alcohol Dependency

❏ Sinus Problems

❏ Rheumatic Fever

❏ Heart Valve Replacement Date:

❏ Heart Stent Date:

Do you currently have, or have you had in the past, any disease, condition or problem not listed above?

❏ Yes ❏ No If yes, please tell us about it

Are you taking any medications: prescribed, over-the-counter or herbal remedies? ❏ Yes ❏ No

List them or attach a copy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (note dose and frequency)

Dental History

Date of last dental/dental hygiene visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What dental conditions concern you at the present time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you receive dental hygiene care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a dental specialist? (i.e., orthodontist, endodontist, prosthodontist,

periodontist) ❏ Yes ❏ No

Have you had dental x-rays in the past two years? ❏ Yes ❏ No

Head and neck radiation therapy? ❏ Yes ❏ No

Do you have or experienced any of the following:

❏ Sensitive teeth (hot or cold)

❏ Cold sores

❏ Bleeding gums (on brushing), sore gums

❏ Loose teeth

❏ Dry mouth

❏ Recession

❏ Bad breath

❏ Swelling, sinus problems

❏ Sore jaw, jaw clicks or pops on opening or closing

❏ Mouth sores

❏ Difficulty chewing

❏ Difficulty swallowing, burning sensation

❏ Calculus (tartar) build-up

❏ Toothache

❏ Fractured or broken filling, abscess

❏ Yellowing or discolouration of teeth

❏ Grinding of teeth

❏ Any accident, injury or surgery to your face, jaw or teeth?

❏ Root planning

❏ Tooth extractions

❏ Dental implants

❏ Root canals

❏ Orthodontics/braces

❏ Severe pain in head, neck or jaw

❏ Prolonged bleeding after dental treatment

❏ Other

Current Oral Condition:

Do you brush your teeth? ❏ Yes ❏ No How often? \_\_\_\_\_\_

Do you floss your teeth? ❏ Yes ❏ No How often? \_\_\_\_\_\_\_\_\_\_

Do you have ❏ complete dentures ❏ partial dentures ❏ fixed bridges ❏ implants

Are you a mouth breather? ❏ Yes ❏ No

Do you favour one side of your mouth? ❏ Yes ❏ No

General Consent Statement: I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge, and have not knowingly omitted any information. Should there be any change in either my health status or any other information I have provided, I will advise the dental hygienist. This information has been reviewed and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician or other health care provider being contacted regarding any specific medical question. I authorize the provider to perform dental hygiene diagnostic procedures as may be required to determine necessary treatment and then to provide the necessary treatment to achieve the proper level of dental hygiene care.

Patient ❏ Parent ❏ Guardian ❏

Date: Signature:

**Informed Consent**

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our office providing you with quality dental hygiene care. We are committed to collecting, using and disclosing your personal information responsibly. All team members are trained in the appropriate uses and protection of your information. Do not hesitate to discuss our policies with any member of our team.

MYRDH Dental Hygiene Spa will collect, use and disclose information about you for the following purposes:

* To identify and to ensure continuous high quality service
* To offer and provide treatment, care and services in relationship to the dental hygiene care
* To communicate with other treating health-care providers, including specialists and general dentists
* To allow us to maintain communication and contact with you, to book and confirm appointments
* To allow us to efficiently follow-up for treatment, care and billing
* To process credit card payments and to collect unpaid accounts
* To assist this office to comply with all regulatory requirements and the law

**Financial Agreement**

* For our non-insured patients: patients are expected to pay for our services at the time they are rendered. Payments may be made using cash, Debit, Visa, and MasterCard.
* For our insured patients: for my convenience, I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to MYRDH Dental Hygiene Spa. Every effort will be made to help me with my insurance but if they do not pay as expected, I will still be responsible. It is my responsibility to pay any deductibles, co-payments and any other fees not paid by insurance.
* I understand that I am financially responsible for all fees whether or not paid by the insurance.
* I authorize MYRDH Dental Hygiene Spa to release all information necessary to secure payment.
* A scheduled appointment means that the Hygienist has reserved a time specifically for you and no other patients are seen at that time. If you know you cannot make your appointment, we require 24 hours’ notice so that we can give your scheduled time to another patient. Patients who do not follow this policy may be charged a fee.

I have reviewed the above information that explains how the office will use my personal information, and the steps your office is taking to protect my information. I agree that MYRDH Dental Hygiene Spa can collect, use and disclose personal information about as set out above.

I have read and understood the financial policy of MYRDH Dental Hygiene Spa

Patient ❏ Parent ❏ Guardian ❏

Date: Signature: