Hollywood Smile
Your Independent Dental Hygienist

WELCOME TO OUR OFFICE

1 About You

Name:

I prefer to be called:

Gender: ☐ Male ☐ Female

Date of Birth: Age:

Home Address:

City: Prov. Postal Code:

Marital Status:

Home Phone:

Cell Phone:

Work Phone: Ext.

Employer:

Occupation:

Whom may we than for referring you?

Other Family members seen by us:

Would you like to receive your dental hygiene recall reminder by email? ☐ Yes ☐ No

Email Address:

2 Spouse Information

Name:

Date of Birth:

Cell Phone:

Work Phone: Ext.

Employer:

Occupation:

3 Insurance

PRIMARY INSURANCE

Insurance Company Name:

Insurance Claim Address:

Address line 2:

Insurance Company Phone:

Insurance Year Ends:

Name of Insured:

Birth Date of Insured:

Relationship to Patient:

Group/Policy #:

Division/Section #:

Certificate/Identification #:

SECONDARY INSURANCE

Insurance Company Name:

Insurance Claim Address:

Address line 2:

Insurance Company Phone:

Insurance Year Ends:

Name of Insured:

Birth Date of Insured:

Relationship to Patient:

Group/Policy #:

Division/Section #:

Certificate/Identification #:

4 In Case of Emergency

Name:

Relationship to You:

Home Phone:

Cell Phone:

Work Phone: Ext.

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5 In Case of Emergency

Name of Medical Doctor:

Phone Number:

Date of Last Visit to Medical Doctor:

Are you taking any drugs or medication at this time?

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

Do you have a medical condition that required you to take antibiotics before receiving dental treatment? ☐ Yes ☐ No

Do you suffer from any allergies (latex, hay fever etc)? ☐ Yes ☐ No

Do you bruise or have prolonged bleeding? ☐ Yes ☐ No

Do you Smoke? How much per day? ☐ Yes ☐ No

Have you ever fainted, had shortness of breath or chest pains? ☐ Yes ☐ No

Women:
Are you Pregnant? ☐ Yes ☐ No
Using Birth Control? ☐ Yes ☐ No
Reached menopause? ☐ Yes ☐ No

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

- ☐ A.I.D.S
- ☐ Anemia
- ☐ Angina pectoris
- ☐ Anorexia nervosa
- ☐ Arthritis/rheumatism
- ☐ Artificial heart valve
- ☐ Artificial joints (hip, knee)
- ☐ Asthma
- ☐ Blood disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Circulation problems
- ☐ Congenital Heart lesions
- ☐ Cortisone/Steroid
- ☐ Diabetes (takes insulin)
- ☐ Diabetes (takes oral meds)
- ☐ Drug/Alcohol dependence
- ☐ Emphysema
- ☐ Epilepsy or seizures
- ☐ Glandular disorders
- ☐ Glaucoma
- ☐ Head/Neck injuries
- ☐ Heart disease/attack
- ☐ Heart Murmur
- ☐ Heart Pacemaker/Surgery
- ☐ Heart rhythm disorder
- ☐ Hepatitis A,B,C
- ☐ Herpes
- ☐ High/Low blood pressure
- ☐ H.I.V. Positive
- ☐ Hodgkins disease
- ☐ Hyper/Hypo Glycemia
- ☐ High/Low Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Malignant hyperthermia
- ☐ Mental/Nervous Disorder
- ☐ Mitral Valve Prolapse
- ☐ Organ Trasplant/Implant
- ☐ Radiation/Chemotherapy
- ☐ Rheumatic/Scarlet fever
- ☐ Sickle Cell disease
- ☐ Sinus trouble
- ☐ Stomach/intestinal pro
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other________________

6 Dental History

Date of last dental visit? Last X-Rays?

Date of last cleaning?

Dentist Name:

Dentist Address:

Phone:

How often do you brush per day? Floss?

Do you use anything in addition to a brush and floss? ☐ Yes ☐ No

If yes, what?

Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never

Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other

Do your gums feel swollen or tender? ☐ Yes ☐ No

Do you have bad breath or a bad taste in your mouth? ☐ Yes ☐ No

Do your jaws crack, pop or grate when you open widely? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you have food catch between your teeth? ☐ Yes ☐ No

Have you ever had local anaesthetic (freezing)? ☐ Yes ☐ No

Any complications? ☐ Yes ☐ No Specify

Have you ever had any problems with previous dental treatments? ☐ Yes ☐ No

Have you ever had:
Bridgework ☐ Orthodontics(braces) ☐
Crowns or Caps ☐ Full/Partial Denture ☐
Root Canal ☐ Periodontal Surgery ☐

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
Rate your smile (on a scale of one to ten) ______________
Would you like to keep all of your teeth for life? ☐ Yes ☐ No

Please rank the following in the order in which they would KEEP YOU from having treatment: (1-5)
___Fear of pain ___Lack of concern ___Missing time from work
___Cost of treatment ___Embarrassed by dental condition

7 Authorization

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowing omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by Hollywood Smile. I authorize Hollywood Smile to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for the treatment received for both myself and my dependents on the day the service is rendered. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

______________________ ______________________
Signature Date

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