SmileOn

Welcome to SmileOn!

Patient Information

First Name: _____

Last Name: _____

Preferred Name: _____

Date of Birth (D/M/Y): _____

Home address: _____

(City)_____ (Postal Code) _____

Employer: _____

Occupation: _____

Contact Information

Email Address:
_____

Mobile phone: _____

Work phone: _____ext.: _____

Home phone: _____

Other phone: _____

Best number to contact: _____Time: _____

Whom should we call in case of an emergency?

Name: _____

Phone: _____

Whom may we thank for referring you?

On-Line ____ Location ____ Advertising ____

Friend (Name)_____

Medical History

Name of family physician? _____

Phone: _____
Date of last visit with physician: _____
Are you currently healthy? Yes_____ No_____
If NO, explain: _____
Do you smoke or chew tobacco? _____
Are you currently taking any prescription medications? _____ If yes, please list below:

Medication	Purpose

Have you had any serious medical problems in the past five (5) years? Yes___ No___

If yes, explain: _____
Have you ever been treated for any of the following

__Heart Attack/Stroke
__Hepatitis/Jaundice
__Epilepsy/Fainting
__Stomach Ulcers/Gerd
__Chronic Pain/Back
__Psychiatric Problems
__Abnormal Bleeding
__Drug/Alcohol Abuse
__Heart Murmur
__HBP
__Cancer/Chemo
__Diabetes
__Tuberculosis
__Kidney Prob.
__Anemia
__Aids

Have you been treated for any other illness not listed above? _____
If yes, explain: _____

Are you allergic to any medication? _____

Any other allergies? _____

_____

For Women

Are you pregnant? _____
If yes, how many months? _____
Is there anything else you feel you should tell us about your health that might affect how we care for you? Please explain: _____
_____

Dental History

Reason for your visit today? _____
_____
_____
_____

How would you describe the condition of your teeth and gums?
_____ GOOD _____FAIR _____POOR

Are you having discomfort or pain with your teeth? or gums? _____
If yes, explain: _____

Date of last dental visit?
(m/y) _____

How often do you brush? _____

How often do you floss? _____

Do your gums bleed when you brush? _____

Have you experienced pain in your jaw joint? ____

Have you been treated for Jaw Pain? ____

Patient Consent

I understand this information to be correct to the best of my knowledge. I understand that it will be held in strict confidence and used only? to improve communications between the doctor and myself. I also give permission for the doctor or staff to use any photos or x-rays for educational purposes.

I have reviewed the information that explains how your office will use my personal information, and the steps your office is taking to protect me information. I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Smile On can collect, use and discuss personal information about me as set out in the SmileOn Privacy Policy.

Direct Billing to Your Insurance

I request for my dentist to bill to my insurance directly and agree that in case of a nonpayment by my insurance, I will be responsible for any outstanding balance after each visit.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____

Office Use Only

Admin Name: _____

Dentist Signature: _____

SmileOn DENTAL

Unit 1 – 111 Shuttleworth Drive
Gloucester Ontario
K1T0W7

www.smileon.ca