Smile DENTAL DESIGN PROFESSIONALS
Dr. Mira T. Šarić-Hecimović

19 Dundas Street West • Mississauga, ON L5B 1H2
905 270 5112 • www.smile-design.ca • info@smiledesigning.ca

PATIENT INFORMATION

Welcome to Our Dental Office! The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the entire form.

PERSONAL INFORMATION

Date: _____
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
First Name: _____
Last Name: _____
Mid: _____ Preferred Name: _____
Date of Birth (DD/MM/YY): _____/_____/_____
Status: ☐ Single ☐ Married ☐ Child ☐ Other
Home Address: _____
Apt: _____ Postal Code: _____
City: _____

Home Tel: _____
Cell: _____
Work Tel: _____
Email: _____
Health Card No.: _____
Employer: _____
Occupation: _____
Physician: _____
Physicians Phone No: _____
Previous Dentist: _____
Pharmacy No: _____

Why have you decided to change dental offices? _____
How did you hear about us? _____
Do you have any specific requests or concerns? _____

INSURANCE INFORMATION 1

Name of insured if different from above: _____
Employer: _____
Insurance Company: _____
Division (If applicable): _____
Do you have Secondary Insurance? ☐ No ☐ Yes

_____
Date of Birth of Insured (DD/MM/YY): _____/_____/_____
Policy/Group: _____
Certificate ID#: _____
(Please fill out the next section if applicable)

INSURANCE INFORMATION 2

Name of insured if different from above: _____
Employer: _____
Insurance Company: _____
Division (If applicable): _____
Person financially responsible for this account: _____

_____
Date of Birth of Insured (DD/MM/YY): _____/_____/_____
Policy/Group: _____
Certificate ID#: _____

Method of Payment: ☐ Cash ☐ Interact ☐ Visa ☐ MasterCard _____ exp. _____/_____ [ ]

*Note: We do accept assignment of benefits if your plan allows, and we will gladly submit your claim on your behalf, however, should insurance not fully reimburse treatment, your portion must be settled at the end of each appointment.

MEDICAL HISTORY

	YES	NO
Are you being treated for any medical condition at the present or have you been treated within the last two years?	☐	☐
If yes, specify: _____		
When was your last medical check-up? _____		
Has there been any change in your general health in the past year?	☐	☐
Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below:	☐	☐

Drug: _____ Reason: _____
Drug: _____ Reason: _____
Drug: _____ Reason: _____
List of surgeries or hospitalizations, including dates: _____

SEE REVERSE

	YES	NO
Do you have any allergies? ☐Latex ☐Other: _____	☐	☐
Have you had an unusual reaction to any drugs or medicines?	☐	☐
☐ Penicillin ☐ Sulfonamide ☐ Aspirin ☐ Codeine ☐ Local Anesthetic ☐ Other: _____		
Have you ever taken cortisone or steroid medication?	☐	☐
Do you have any sinus problems?	☐	☐
Do you have or have you ever had any heart problems?	☐	☐
Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?	☐	☐
Do you or have you ever had jaundice, hepatitis or liver disease?	☐	☐
Do you have a bleeding problem or bruise easily? Are you on blood thinner?	☐	☐
Do you have any conditions that could affect your immune system eg: AIDS, HIV infection, Leukemia etc?	☐	☐
Do you smoke? If yes, how much? _____	☐	☐
Do you have any prosthetic or artificial joints?	☐	☐
Are you on a special diet? Describe: _____		
Do you have or have you ever had any of the following?		

☐ Chest Pain/Angina ☐ Heart Attack ☐ High Blood Pressure ☐ Emphysema ☐ Asthma
☐ Epilepsy ☐ Thyroid Disease ☐ Kidney Disease ☐ Cancer ☐ Chemotherapy/Radiation
☐ Psychiatric Disorder ☐ Tuberculosis ☐ Arthritis ☐ Stroke ☐ Pacemaker
☐ Stomach Ulcers ☐ Diabetes ☐ Drug/Alcohol Dependency

For females: Are you pregnant or breast feeding? Which trimester? _____	☐	☐
Any other conditions or problems of which the dentist should be aware?	☐	☐
If yes, please list: _____		

DENTAL HISTORY

When was your last dental visit? _____		
When did you last have dental x-rays? _____		
Have you been seeing a dentist regularly? How often? _____	☐	☐
Do any of your teeth ache?	☐	☐
Do you drink coffee or tea with sugar or honey?	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐
Are your teeth sensitive to hot, cold, sweets, biting pressure? **(Circle)**	☐	☐
Do you feel that you have bad breath?	☐	☐
Have you ever been in a motor vehicle accident or experienced any blows to your jaw?	☐	☐
Have you ever had any teeth removed? Please note any complications: _____	☐	☐
Please list anything else not mentioned above regarding your past dental history: _____		
Are you interested in a complimentary consultation for orthodontics (Braces or Invisalign)? **(Circle)**	☐	☐

SLEEP HISTORY:

Do your grind or clench your teeth at night?	☐	☐
Does your snoring keep you or your family awake?	☐	☐
Do you sleep well through the night? If no, how often do you wake-up? _____	☐	☐
Do you wake-up with a headache?	☐	☐
Do you wake-up feeling fully rested?	☐	☐
Have you ever had a sleep study (PSG)? If yes, what were the results? _____	☐	☐

ACKNOWLEDGEMENT & PERMISSION FOR TREATMENT / PROMISE OF PAYMENT / ELECTRONIC CLAIMS SUBMISSION / PRIVACY POLICY

I certify that I have read, understood and accurately completed the personal, medical and dental histories, to the best of my knowledge, and not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. I authorize the dentist to perform necessary diagnostic procedures and treatment, including photos, general and local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive. I agree to accept full responsibility for payment including collection costs ($10 per month on accounts over 30 days). I authorize this office to charge my credit card in the amount of any NSF or stopped payment cheques plus bank charges should any payments not clear my account. I also release to my insurance company / plan administrator, the information contained in claims submitted electronically. I have read and understand the information that explains how this office will use my personal information, and the steps this office is taking to protect my information according to Privacy Regulations. I also authorized the dentist to use my email and or cell phone number to confirm/re-schedule appointments, send enewsletters or any vital electronic information that may help me keep informed about my oral health. I understand that I can unsubscribe at any time.

_____	_____	_____	_____
Signature of Patient	DD/MM/YYYY	Reviewed by Dentist	DD/MM/YYYY