Smile DESIGN DENTAL PROFESSIONALS
Dr. Mira Šarić-Hecimović

19 Dundas Street West. Mississauga, ON L5B1H2
905 270 5112 info@smiledesigning.ca www.smile-design.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

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms.

First Name: _____

Last Name: _____

Mid Name: _____ Preferred Name: _____

Date of Birth (DD/MM/YY): _____ / _____ / _____

Status: ☐ Single ☐ Married ☐ Child ☐ Other

Home Address: _____
Unit Street

City _____ Postal Code _____

WHO REFERRED YOU TO OUR OFFICE?

☐ Online ☐ Sign ☐ Family / Friend ☐ Other: _____

Today's Date: _____

Home Tel: _____

Cell: _____

Email: _____

Employer: _____

Occupation: _____

Work Tel: _____

Physician: _____

Physicians Phone Tel: _____

Health Card No.: _____

Pharmacy Tel: _____

Previous Dentist: _____

Why have you decided to change dental offices?

_____

Do you have any specific requests or concerns?

_____

INSURANCE INFORMATION

Do you have dental insurance? ☐ Yes* ☐ No ☐ ODSP ☐ Healthy Smiles Ontario

*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
1. Are you being treated for any medical condition at the present or have you been treated within the last two years?	☐	☐

2. If yes, specify: _____

3. When was your last medical check-up? _____

4. Has there been any change in your general health in the past year? _____

5. Are you taking any medications or non-prescription drugs of any kind? If yes, please list them below: (Please use reverse if you require more space)

Drug: _____ Dosage: _____ Reason: _____

Drug: _____ Dosage: _____ Reason: _____

Drug: _____ Dosage: _____ Reason: _____

6. Do you take medications for osteoporosis? (e.g. Fosamax, Actonel) _____	☐	☐
7. Do you have any allergies? ☐ Latex ☐ Other: _____	☐	☐

8. List of surgeries or hospitalizations, including dates: _____

_____

9. Have you had an unusual reaction to drugs or medicines? _____

☐ Penicillin ☐ Sulfonamide ☐ Aspirin ☐ Codiene ☐ Local Anesthetic ☐ Latex ☐ Food ☐ OTHER: _____

	YES	NO
10. Do you have any sinus problems?	☐	☐
11. Do you have or have you ever had any heart problems, heart murmur, mitral valve prolapse or rheumatic fever?	☐	☐
12. Do you have any conditions that could affect your immune system e.g. AIDS, HIV infection, jaundice, hepatitis or liver disease?	☐	☐
13. Do you have a bleeding problem or bruise easily? Are you on blood thinner?	☐	☐
14. Do you have any prosthetic or artificial joints?	☐	☐
15. Do you smoke? If yes, how much?	☐	☐
16. Are you on a special diet? Describe:	☐	☐

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

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

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

DENTAL HISTORY - NEW PATIENTS ONLY

20. Have you been seeing a dentist regularly? How often?	☐	☐
When was your last visit?		
21. Do you drink coffee or tea with sugar or honey?	☐	☐
22. When did you last have dental x-rays?		
23. Are your teeth sensitive to: ☐ HOT ☐ COLD ☐ SWEETS ☐ BITING PRESSURE ☐ OTHER:		
24. Do your gums bleed?	☐	☐
25. Have you ever had any teeth removed and experienced any complications?	☐	☐
26. Have you ever been advised to take antibiotics before dental appointments?	☐	☐
27. Is there anything you dislike about your smile?	☐	☐
28. Have you ever been in a motor vehicle accident where you experienced any blows to your jaw	☐	☐
29. Are you interested in a complimentary orthodontic consultation? (Invisalign)	☐	☐
30. Do your grind or clench your teeth at night?	☐	☐
31. Are you nervous during dental treatment?	☐	☐

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 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 (Parent / Guardian)	DD/MM/YYYY	Reviewed by Dentist	DD/MM/YYYY

Doctor's Notes: