Complete
Dental Hygiene

Welcome Form

E-mail: Today's Date:

Personal

Name: Home Phone: Business: Cell:

Last First Middle ( ) ( ) ( )

Address: City: Province: Postal Code:

Occupation: Date of birth: Sex: M F

Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( )

Insurance

Name of Primary insuring agency or plan: Policy Holder: Employer:

Group Policy/Plan Number: Certificate/ I.D. Number: Division/Section Number:

Name of Secondary insuring agency or plan: Policy Holder: Employer: Date of birth:

Group Policy/Plan Number: Certificate/ I.D. Number: Division/Section Number:

Dental Information

For the following questions, please mark (X) your response. (Check DK if you Don't Know the answer)

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatment?	☐	☐	☐
Have you had orthodontic (braces) treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pain?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have any sores in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you have any dental implants?	☐	☐	☐

Date of last dental exam: _____
What was done at that time? _____
_____
Date of last dental x-rays: _____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following.

Dentist name and number: _____
Physician name and number: _____

	Yes	No
Has there been any changes in your general health within the past year?	☐	☐

If so please explain: _____
_____

Date of last physical exam:

Have you had a serious illness, operation or been hospitalized in the past 3 years?	☐	☐

If so please explain: _____
_____

	Yes	No	DK
Are you taking any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list it all including vitamins, natural/herbal and diet supplements:
_____
_____

Do you use any tobacco products?	☐	☐	☐
Do you vape or use marijuana products?	☐	☐	☐
Women Only:			
Are you pregnant?	☐	☐	☐

If so how many weeks _____

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following.

Allergies -Are you allergic to or have you had a reaction to:	Yes	No	DK		Yes	No	DK
Local anesthetics	☐	☐	☐	Metals	☐	☐	☐
Aspirin	☐	☐	☐	Latex	☐	☐	☐
Penicillin or other antibiotics - Specify:_____	☐	☐	☐	Iodine	☐	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	☐	Food - Specify_____	☐	☐	☐
Sulfa drugs	☐	☐	☐	Other - Specify_____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following.

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Heart disease	☐	☐	☐	Tuberculosis	☐	☐	☐	Hepatitis A, B or C	☐	☐	☐
Heart murmur	☐	☐	☐	Arthritis	☐	☐	☐	HPV	☐	☐	☐
Congestive heart failure	☐	☐	☐	Rheumatism	☐	☐	☐	Liver disease	☐	☐	☐
Angina	☐	☐	☐	Autoimmune Disease	☐	☐	☐	Eating disorder	☐	☐	☐
Rheumatic fever	☐	☐	☐	Asthma	☐	☐	☐	Gastrointestinal disease	☐	☐	☐
Artificial heart valve	☐	☐	☐	Bronchitis	☐	☐	☐	GE reflux/heartburn	☐	☐	☐
Heart attack	☐	☐	☐	Hay fever	☐	☐	☐	Epilepsy	☐	☐	☐
Heart pacemaker	☐	☐	☐	Sinus trouble	☐	☐	☐	Fainting or dizzy spells	☐	☐	☐
Mitral valve prolapse	☐	☐	☐	Headaches	☐	☐	☐	Alzheimer's disease	☐	☐	☐
High blood pressure	☐	☐	☐	Mental health challenges	☐	☐	☐	Cold sores	☐	☐	☐
Low blood pressure	☐	☐	☐	Brain injury	☐	☐	☐	Kidney problems	☐	☐	☐
Congenital heart disease	☐	☐	☐	Lupus	☐	☐	☐	Sleep Apnea	☐	☐	☐
Heart surgery	☐	☐	☐	Cancer - Type _____	☐	☐	☐	Osteoporosis	☐	☐	☐
Anemia	☐	☐	☐	Chemotherapy	☐	☐	☐	Sexually transmitted disease	☐	☐	☐
Hemophilia	☐	☐	☐	Artificial joint	☐	☐	☐	Sleep disorder	☐	☐	☐
Blood transfusion	☐	☐	☐	Diabetes	☐	☐	☐	Multiple sclerosis	☐	☐	☐
AIDS or HIV infection	☐	☐	☐	Thyroid disease	☐	☐	☐	Celiac disease	☐	☐	☐
Stroke	☐	☐	☐	Chronic pain	☐	☐	☐	Malignant hypothermia	☐	☐	☐
Ulcers	☐	☐	☐	Glaucoma	☐	☐	☐	Other: _____			

Please tell us how you found out about our clinic!:_____

Client Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time of service rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment. We accept the following forms of payment: cash, debit cards and credit cards.

Dental Benefits Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan provider. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to assist our clients with dental benefit plans to understand their coverage. You are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the client's portion (deductible, co-pay or any amount not covered by the dental plan) in full at the time of service.

Scheduling of Appointments: We reserve the hygienist's time on the schedule for each client procedure and are diligent about being on time. Because of this courtesy, when a client cancels an appointment, it affects the overall service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $50.00 or deposit to reserve the appointment time again, may be required. To reschedule an appointment due to late arrival, a fee of $50.00 may be required.

Client Authorizations

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment

I have read the above and agree to the financial and scheduling terms

I authorize the release of information necessary to process my dental benefit claims and authorize payment directly to this office

Client/Legal Guardian Signature: _____ Date: _____

Print Name: _____