Mint Dental.CA
Healthy ~ Beautiful ~ Fresh
2609 St. John's Street, Port Moody, BC V3H 2B6

First Name: _____
Last Name: _____
Prefers: _____
Date of Birth: Day ___Month _____Year _____
Address: _____
City: _____
Province: _____ Postal Code: _____
Home Phone: _____
Cell Phone: _____
Business Phone: _____

E-mail: _____
Employer: _____
Occupation: _____
In case of emergency, please notify:
_____ Phone___ _____

Referred by:
- ☐ Friend
- ☐ Newspaper
- ☐ Flyer
- ☐ Walk-in
- ☐ Other

MEDICAL HISTORY

1. My last medical examination was on (approximate) _____
2. Are you under the care of a physician? _____ ☐YES ☐NO
3. Name of Physician:_____ Address:_____
4. Have you been hospitalized within the last 5 years ? ☐YES ☐NO If yes, please explain why: _____
5. Are you currently taking any medication , prescription or non-prescription? Please list:
   Drug : _____ Purpose: _____ Drug : _____ Purpose: _____
   Drug : _____ Purpose: _____ Drug : _____ Purpose: _____
6. Have you been told that you require antibiotic prophylaxis before dental visits? ☐YES ☐NO
7. Indicate which of the following you presently have or ever had:

YES	NO		YES	NO		YES	NO	
		Infectious Diseases	☐	☐	Rheumatic fever	☐	☐	Bowel disease
☐	☐	A.I.D.S./+ve HIV test	☐	☐	Pacemaker	☐	☐	Liver disease
☐	☐	Hepatitis A	☐	☐	High/low blood pressure	☐	☐	Kidney/bladder disease
☐	☐	Hepatitis B	☐	☐	Angina	☐	☐	Frequent vomiting
☐	☐	Hepatitis C	☐	☐	Swollen ankles	☐	☐	Follow a special diet
☐	☐	Tuberculosis	☐	☐	Stroke	☐	☐	Loss/gain 10lbs or more/yr.
		Musculoskeletal Condition			**Hematological Disorders**			
☐	☐	Arthritis	☐	☐	Hemophilia			**Other Conditions**
☐	☐	Artificial joints	☐	☐	Leukemia	☐	☐	Smoker
☐	☐	Osteoporosis	☐	☐	Anemia	☐	☐	History drug/alcohol abuse
		Neural Disorders	☐	☐	Blood transfusion	☐	☐	Organ transplant
☐	☐	Epilepsy of seizures	☐	☐	Bruise easily	☐	☐	Cancer or tumour
☐	☐	Severe headaches	☐	☐	Prolonged bleeding	☐	☐	Other_____
☐	☐	Fainting			**Respiratory Diseases**			
☐	☐	Dizzy spells	☐	☐	Asthma			**Sensitivities/Allergies**
☐	☐	Nervousness	☐	☐	Bronchitis	☐	☐	Penicillin allergy
☐	☐	Eating disorder	☐	☐	Emphysema	☐	☐	Allergy to other medications
		Endocrine Disorders	☐	☐	Pneumonia	☐	☐	Local Anesthetic
☐	☐	Diabetes	☐	☐	Sinus problems	☐	☐	Food
☐	☐	Thyroid disease	☐	☐	Chronic cough	☐	☐	Metal
☐	☐	Cortisone/steroid therapy	☐	☐	Shortness of breath	☐	☐	Latex
		Cardiovascular Diseases			**Gastrointestinal Disorders**			Other_____
☐	☐	Heart attack	☐	☐	Reflux esophagitis	☐	☐	If Yes to any of the above, does
☐	☐	Heart failure	☐	☐	Ulcer			it result in swelling, shortness
☐	☐	Heart arrhythmia	☐	☐	Bowel disease			of breath or chest constrictions?
☐	☐	Heart surgery	☐	☐	Liver disease			
☐	☐	Heart murmur	☐	☐	Kidney/bladder disease			**Women Only**
☐	☐	Congenital heart defect			**Gastrointestinal Disorders**	☐	☐	Pregnant Week#_____
☐	☐	Mitral valve prolapse	☐	☐	Reflux esophagitis	☐	☐	Nursing
☐	☐	Artificial heart valve	☐	☐	Ulcer			

8. Do you have any diseases, conditions, or problems not listed above that you think we should know? ☐YES ☐NO
   Please indicate: _____

DENTAL HISTORY

1. Have you had a dental exam in the last year? Last Visit? _____

2. When was your last dental x-rays? _____

3. Do you have any oral habits such as grinding your teeth, clenching or nail biting? _____

4. Do you have/use a night guard? _____

5. How often do you brush your teeth? _____ /day Floss you teeth? _____ /week

6. Do any of your teeth hurt? Broxen? Sensitive? _____

7. Do your gums bleed while you brush? _____

8.Do you have pain when you chew? _____

9. Do you have bad breath? _____

10. What concerns do you have? _____

_____

_____

11. How can we help to improve your smile? _____

_____

_____

12. Which one of the following would like to know more about:

- ☐ Botox & Fillers
- ☐ Implants
- ☐ Whitening
- ☐ Smile Makeover
- ☐ Invisalign
- ☐ Veneers
- ☐ Sedation Dentistry
- ☐ Children's Dentistry

I, _____ do hereby consent to the release of dental and medical information, including clinical records and x-rays relative to my health care to Mint Dental. I authorize the release, to my insuring company plan adiminstrator, the corresponding fees. I acknowledge that any fees **not** paid by my insurance company are my responsibility and estimates are subject to change due to unforeseen treatment. I am aware that Mint Dental will bill my insurance as a courtesy; however they are not responsible for my plan and may not know my information due to the privacy act of B.C. I understand that a possibility of complications exists for each treatment. In addition, **48 hours notice is required for appointment change** otherwise a $75 cancellation fee will apply.

Date: _____ Siganture: X _____

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