

**MEDICAL ALERT**

**Patient ID#**



**MOBILElifestyles**  
Dental Hygiene & Whitening Services

**Telephone 905-636-9165**

**Email: [carrie@mobilelifestyles.ca](mailto:carrie@mobilelifestyles.ca)**

**www.mobilelifestyles.ca**

**Patient Information**

Name: \_\_\_\_\_  
(First) (Initial) (Last)

Address: \_\_\_\_\_  
(Apt#) (Street) (City) (Prov.) (Postal Code)

Birthdate: \_\_\_\_\_ mth/ \_\_\_\_\_ day/ \_\_\_\_\_ year Home Tel : (\_\_\_\_) \_\_\_\_\_ Cell : (\_\_\_\_) \_\_\_\_\_ Work : (\_\_\_\_) \_\_\_\_\_

Age: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Tel : (\_\_\_\_) \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Tel : (\_\_\_\_) \_\_\_\_\_

Family Doctor Address: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Referred By: \_\_\_\_\_

**Insurance Information**

Person responsible for account (full name) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group# \_\_\_\_\_

Policy # \_\_\_\_\_ Certificate# \_\_\_\_\_

**Secondary Insurance**

Person responsible for account (full name) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Policy # \_\_\_\_\_ Certificate # \_\_\_\_\_

**Financial Information**

Method of Payment:  Cash  MasterCard  Visa  Debit  Cheque  AMEX

## Medical History

(This information will remain strictly confidential) Date: \_\_\_\_\_

- |  | YES  | NO  |  |
|--|--|---|--|
| 1. Are you being treated for any medical condition at the present or have you been treated within the past year?<br>If so, why? _____  | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 2. When was your last medical checkup or visit? _____  |  |   |  |
| 3. Has there been any change in your general health in the past year?<br>If yes, please explain. _____   | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 4. Are you taking any <b>medications, non-prescription drugs or herbal supplements</b> of any kind?<br>If yes, please list. _____  | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 5. Do you have any <b>allergies</b> ? If you answered yes, please list using the categories below:<br>Medications _____<br>Latex/rubber products _____<br>Other (e.g. hay fever, foods, skin) _____                  | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 6. Do you have or have you ever had asthma, breathing or lung problems? _____  | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 7. Do you have or have you ever had any heart or blood pressure problems? _____  | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 8. Do you have or have you ever had an artificial heart valve, an infection of the heart (i.e. infective endocarditis),<br>a heart condition from birth (i.e. congenital heart disease) or a heart transplant? _____ | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 9. Do you have a prosthetic or artificial joint? _____   | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 10. Do you have any conditions or therapies that could affect your immune system?<br>E.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? _____   | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 11. Have you ever had hepatitis, jaundice or liver disease? _____  | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 12. Do you have a bleeding problem or bleeding disorder? _____   | <input type="checkbox"/>                         | <input type="checkbox"/>                          |  |
| 13. <b>Women: Are you pregnant?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Are you using birth control?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO                            |  |   |  |
| 14. Do you have or have you ever had any of the following? Please check:   |  |   |  |
| <input type="checkbox"/> A.I.D.S.  | <input type="checkbox"/> Cortisone/steroid       | <input type="checkbox"/> High/Low blood pressure  | <input type="checkbox"/> Psychiatric disorder        |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> H.IV. Positive           | <input type="checkbox"/> Radiation/chemotherapy      |
| <input type="checkbox"/> Angina Pectoris   | <input type="checkbox"/> Drug/alcohol dependence | <input type="checkbox"/> Hodgkin's Disease        | <input type="checkbox"/> Rheumatic/Scarlet Fever     |
| <input type="checkbox"/> Anorexia nervosa  | <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Hyper/Hypo glycemia      | <input type="checkbox"/> Sickle Cell disease         |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Hypertension             | <input type="checkbox"/> Sinus trouble               |
| <input type="checkbox"/> Arthritis/rheumatism  | <input type="checkbox"/> Glandular disorders     | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Stomach/intestinal problems |
| <input type="checkbox"/> Artificial Joints (hips, Knee)  | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Kidney disease           | <input type="checkbox"/> Stroke                      |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Head/neck injuries      | <input type="checkbox"/> Liver disease            | <input type="checkbox"/> Thyroid disease             |
| <input type="checkbox"/> Blood disorders   | <input type="checkbox"/> Heart disease/attack    | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Bronchitis  | <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Lung disease             | <input type="checkbox"/> Ulcers                      |
| <input type="checkbox"/> Bulimia   | <input type="checkbox"/> Heart pacemaker/surgery | <input type="checkbox"/> Malignant hypothermia    | <input type="checkbox"/> Venereal                    |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Heart rhythm disorder   | <input type="checkbox"/> Mental/nervous disorder  | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Circulation problems  | <input type="checkbox"/> Hepatitis A/B/C         | <input type="checkbox"/> Mitral Valve Prolapse    | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Congenital heart lesions  | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Organ transplant/implant | <input type="checkbox"/> <b>NONE</b>                 |

# Dental History

## History:

1. How long ago was your last dental/dental hygiene visit? \_\_\_\_\_
2. Name of your current or previous dentist: \_\_\_\_\_ Tel : (\_\_\_\_) \_\_\_\_\_
3. Are you under the care of a dental specialist? (i.e., orthodontist, endodontist, pedodontist, prosthodontist, periodontist)  Yes  No
4. How many medical and dental x-rays have you had in the past five years? \_\_\_\_\_
5. Have you ever had any complications or bad experiences following dental treatment?  Yes  No
6. In order that we may be sensitive to your needs, please tell us of any unpleasant experiences you may have had related To oral care: \_\_\_\_\_
7. Have you ever had the following?  
 Bridgework  Crowns or Caps  Root Canal  Periodontal/Gum Disease  Braces  Dentures

## Concerns:

8. What dental conditions concern you at the present time?
9. Do you presently have?  
 Recession  Sensitive teeth  Bleeding gums  Sore gums  Tartar/calculus build-up  
 Mouth sores  Cold sores  Dry mouth  Bad breath  Sore jaw  
 Loose teeth  Grinding of teeth  Broken filling  Swelling  Toothache  
 Abscess  Sinus problems  Burning sensation  Yellowing or discolouration of teeth  
 Difficulty chewing  Difficulty swallowing  
 Accident, injury or surgery to your face, jaw or teeth
10. Are your teeth sensitive to:  Cold  Sweets  Heat  Other
11. Do your gums bleed when:  Brushing  Flossing  Other  Never
12. Rate your smile from 1 to 10 (1 = very unsatisfied, 10 = very satisfied)  
1    2    3    4    5    6    7    8    9    10

## Habits:

13. Do you smoke? If yes, how many per day? \_\_\_\_\_ Years smoked? \_\_\_\_\_  Yes  No
14. Do you consume alcohol regularly? If yes, how many drinks per day \_\_\_\_\_ /week \_\_\_\_\_  Yes  No
15. Do you grind or clench your teeth?  Yes  No
16. Are you a mouth breather?  Yes  No
17. Do you have food catch between your teeth?  Yes  No
18. Have you ever had local anaesthetic (freezing) for dental cleaning?  Yes  No
19. How often do you Brush per day? \_\_\_\_\_ Floss ? \_\_\_\_\_ Mouth Rinse ? \_\_\_\_\_

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## GENERAL RELEASE/PATIENT CONSENT

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as required by **Carrie Burke of Mobile Lifestyles Dental Hygiene & Whitening Services**. I authorize this dental hygienist to perform assessment procedures as required to determine the necessary treatment. I understand that it is my responsibility for fees associated with my dental treatment or dental assessments. I understand that restorative treatments and x-rays are not services provided by Mobile Lifestyles and that it is necessary to follow up with a dentist on a regular basis to maintain optimal oral health.

**Disclosure:** I understand that treatment or product fees may be reasonably set, by the dental hygienist, above or below the ODHA suggested fee guide for dental hygienists, in which may benefit the business interest of the dental hygienist and/or associates.

**Policy:** I understand that I must provide at least 24 hours notice for cancellation of appointments or a cancellation fee will or may be applied to my account.

\_\_\_\_\_  
Signature:  Self  Parent/Guardian

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Registered Dental Hygienist Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date