Creative Smiles Dental Clinic
Dr. Emmanuel V. Enguito, D.M.D.
(403) 226 3677

# Adult New Patient Medical Form

**Welcome to Creative Smiles Dental Clinic. In order to provide you with you the best dental experience, please complete the following confidential information.**

## PATIENT INFORMATION

Last name:_____ First name: :_____Preferred name: :_____
Date of birth:_____

Mailing address:_____ City:_____ Prov: _____Postal code: _____

Home phone:_____ Work: _____ Cell: _____

Email: _____

Emergency contact name: _____ Phone number: _____

**MEDICAL HISTORY** please circle **yes or no** to the following

Are you under the care of a physician? YES NO

Date of last physical exam: _____

Were any problems indentified? If **YES** please explain:_____ YES NO

Are you taking any medications? YES NO
Please list what you are taking, including herbs or vitamins _____

Have you had recent exposure to communicable infectious diseases in the last 24 hrs? YES NO
(Measles, TB, chicken pox, influenza, etc. or travel to an endemic area)?

Are you allergic to or ever had an allergic reaction to the following: YES NO

☐ **Penicillin** ☐ **local anesthetic** ☐ **latex** ☐ **codeine** ☐ **aspirin** **other** _____

Do you now have or have you ever had any of the following conditions? (Please circle)

| | | |
|---|---|---|
| ☐ Heart conditions (murmur) | ☐ blood disorders | ☐ HIV positive |
| ☐ Breathing problems | ☐ tumors or cancer | ☐ epilepsy or seizure |
| ☐ Rheumatic fever | ☐ asthma | ☐ high cholesterol |
| ☐ High or low blood pressure | ☐ kidney or liver disease | ☐ digestive disorders |
| ☐ Diabetes | ☐ mental illness | ☐ drug or alcohol dependency |
| ☐ Joint surgery | ☐ thyroid | ☐ stroke |
| ☐ Hepatitis | | |

Are you a smoker or previously smoked? _____ YES NO

Do you bleed more or longer than normal after a cut, surgery or tooth removal? YES NO

For woman only, are you pregnant? YES NO

Is there anything else about your health we should know? _____ YES NO

**SIGNATURE OF PATIENT**: _____ **DATE**:_____

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# Adult Dental History Form

Name:_____ Date: _____

Referred by? _____

Previous dentist: _____

Date of most recent dental exam and x-rays: _____

Date of most recent dental cleaning: _____

**PERSONAL DENTAL HISTORY**: (Please circle **yes or no** to the following)

| | | |
|---|---|---|
| Are you fearful of dental treatment? | YES | NO |
| You ever had complications from past dental treatment? | YES | NO |
| Have you ever had problems getting numb or had any reactions to local anesthetic? | YES | NO |
| Have you ever had braces or orthodontic treatment? | YES | NO |
| Is there anything about the appearance of your teeth that you would like to change? | YES | NO |
| Do you have problems with your jaw joint? (Pain, clicking, limited opening) | YES | NO |
| Do you clench or grind your teeth in the day or nighttime? | YES | NO |
| Do you snore? | YES | NO |
| Do your gums bleed when brushing or flossing? | YES | NO |
| Have you ever noticed an unpleasant taste or order in your mouth? | YES | NO |
| Do you get food caught in between your teeth? | YES | NO |
| Are any of your teeth sensitive to hot, cold biting, sweets, or avoid brushing any Part of your mouth? | YES | NO |

Patient's signature: _____ date:_____

Doctor, hygienist/assistant's signature: _____ date:_____

Updated: _____