Olu Brown RDH, DipDH, BDH
SmartSmilesDentalHygiene@gmail.com
902.830.6908

3242 Novalea Dr.
Halifax
455-1636

193 Portland St.
Dartmouth
464-0808

Smart Smiles Dental Hygiene

Patient Information Form (Confidential) **Date_____**

Last Name_____First Name_____M____

Address_____ City_____

Prov_____Postal_____Phone_____ Cell_____

Date of Birth_____ M / F Occupation_____

I, _____ hereby consent to have Smart Smiles Dental Hygiene provide Dental Hygiene services for myself or _____Dental Insurance Yes / No

Emergency Contact Person_____ Phone# _____

How did you hera about us? _____

Insurance Provider_____ Group #_____

Policy # _____ % of coverage_____

Name of Employer _____

Secondary Insurance? Yes / No Name _____

How many family members in your household ?_____

Name Of Physician _____ Office _____

Do you suffer from allergies or medical conditions? Yes / No If yes please explain_____

_____

Are you allergic or have had any of the following conditions?

☐ Penicillin	☐ Sulfa Drugs	☐ Latex	☐ Local Anesthetic
☐ Heart Condition	☐ Diabetes	☐ Cancer	☐ Valve Replacement
☐ Hospitalized	☐ HIV	☐ Herpes	☐ Hep B/C
☐ Stroke	☐ Asthma	☐ Arthritis	☐ Respiratory Problems
☐ Angina	☐ Chest Pain	☐ Seizures	☐ Hay Fever

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☐ Glaucoma ☐ Thyroid Problems ☐ Anemia ☐ Irritable Bowel Disease

If yes then please explain _____
_____

Do you have any concerns about your teeth?_____
_____

When was your last Dental Hygiene Appointment?_____

Would you like to tell us more about yourself? _____

I,_____accept full financial responsibility for services rendered

Name of Patient_____ Relationship to Patient_____