THE SMILE CENTRE

COSMETIC/FAMILY DENTIST

DR. CAMILLE M. HOPE

WELCOME TO OUR PRACTICE

Thank you for choosing our practice for your dental needs. Please complete this form. If you have any questions, do not hesitate to ask for assistance. We would like to inform you of our behaviour management fee for children who may need extra time in the chair.

PATIENT INFORMATION

Name:_____

Mr___Mrs___Dr___Miss___Ms_____

Address:_____

_____

Business Address:_____

_____

Occupation:_____

Date of Birth (DD/MM/YY)_____

Home Phone:_____

Business Phone:_____

Mobile:_____

Email:_____

Insurance Co:_____

Name of Parent(if minor)_____

Whom may we thank for referring you to us?_____

Are you available for short notice appointments?_____

DENTAL HISTORY

Reason for today's visit: _____

Please tick the following conditions that apply:

Cavity ☐ Pain ☐ Bad breath ☐ Food/space between teeth ☐ Sores ☐

Stains ☐ Popping Jaw ☐ Grinding teeth ☐ Bleeding Gums ☐ Loose teeth ☐

Sensitive teeth ☐ Broken fillings ☐

The greatest compliment our patients can give is the referral of their family and friends.
Thank you for your trust.

Would you like to know more on the following:

---Our extreme make-over service
---Tooth Contouring
---Crowns and Bridges
---Valplast Dentures
---Teeth Whitening
---Thumb Sucking Appliance
---TMJ (jaw) Appliance
---Night Guard
---Space Maintainers
---Implants
---Biologic Dentistry

We also offer the following Non-Clinical services:

Bad Breath Management
Dental Nutrition Counseling
Anxiety Management
Sleep Disturbances
Pregnancy and Dental Health
Oral Hygiene Instructions
Getting to know you programs for Kids
Teeth Grinding Analysis
Sports Dentistry

MEDICAL HISTORY

Do you smoke?_____
Have you ever been hospitalized?_____

Are you pregnant?_____
Are you taking birth control pills?_____

Please list any medications you are taking_____

Please state any allergies that you may have_____

Please indicate if any of the following pertain to you:

__Aids
__Anemia
__Auto Immune Disorder
__Blood Disease
__Cancer
__Chemotherapy
__Thyroid problems
__Asthma
__Circulation Problems
__Diabetes
__Epilepsy
__Fainting
__Glaucoma
__HIV Positive
__Bleeding Gums
__Other
__Hepatitis
__Heart condition/surgery
__High Blood Pressure
__Kidney Disease
__Liver Disease
__Sickle Cell
__Sinusitis

The nature of our practice is to give our patients the utmost in care and service. We try not to keep you waiting but delays are sometimes unavoidable. We offer a 5% discount for any delay over 30 minutes.

We know your time is valuable and so is ours, therefore we would appreciate 24 hour notice for cancellations.

Authorisation

I certify that I have read and understood the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the Dentist to release any information including the diagnosis and records of any treatment or examination rendered me or my child during the period of such dental care to health practitioners or third party payees.

_____ _____

Signature of Patient (or Parent/Guardian of a Minor) **Date**