THE BEACONHILL SMILE CLINIC
8a Adeola Odeku Street, Victoria Island, Lagos.
Tel: 0700-MYDENTIST (0700-693368478), 08125215208
www.beaconhillsmile.com

Thank you for selecting our dental team!
We will strive to provide you with best possible dental care.

PATIENT INFORMATION

Patient No.: _____

Date: _____

Name: _____

Address: _____

DOB: _____ Age: _____ Sex ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Child ☐ Widowed ☐ Divorced ☐ Other:

Nationality: _____

State of origin: _____ Religion _____

Home Phone: _____ Cell Phone _____

Email Address: _____

_____

If Student Name of School/College _____

_____

City: _____ State: _____ Full Time ☐ Part Time ☐

Employer: _____

City: _____ State: _____ Phone: _____

Emergency Contact: _____

Cell Phone: _____ Home Phone: _____

Next of kin:

Name: _____

Address: _____

_____

Phone: _____ Relationship: _____

If minor, head of family:

_____
Surname First Name

Tel. No: _____

*Payment: ☐ Cash ☐ Cheque Invoice to Company ☐ Invoice to Private ☐

Please give details

Name of company: _____

Address: _____

_____

Tel No. _____

Invoice to Insurance Company ☐

Name of Insurance Company _____

Address: _____

_____

Tel: _____

Fax No: _____ Policy No: _____

Registered address with the insurance company

_____

Whom may we thank for referring you?

_____

Although we primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions honestly and completely.

DENTAL HISTORY

Date of Last Dental Care _____

Date of Last Dental X-Rays _____

Fomer Dentist Name _____

Are you having or have you had any of the following

- ☐ Pain in Teeth
- ☐ Sensitivity to Sweets
- ☐ Sensitivity when Biting
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Cold
- ☐ Broken Teeth or Fillings
- ☐ Periodontal or Gum Disease
- ☐ Bleeding Gums
- ☐ Loose Teeth
- ☐ Bad Breath
- ☐ Food Collection Between Teeth
- ☐ Difficult/Surgical Extractions
- ☐ Frequent Headaches
- ☐ Grinding or Clenching
- ☐ Clicking or Jaw Popping
- ☐ Head, Neck, or Jaw Injuries
- ☐ Sores or Growths in or Around Mouth
- ☐ Orthodontic Treatment

Are you having or have you had any other concerns with your mouth and/or teeth?

HOW DO YOU LIKE YOUR SMILE?

Rate your smile:

HELP It! (1) (2) (3) (4) (5)

(6) (7) (8) (9) (10) LOVE It!

What, if anything, would you change about your smile?

_____

_____

_____

_____

Would you like more information on:

☐ Bleaching ☐ Veneers/Cosmetic Dentistry

☐ Implants ☐ Oral Cancer

☐ Other: _____

MEDICAL HISTORY

Physician's Name _____

Date of Last Visit _____

How long ago was blood pressure checked? _____

_____

Approximate Reading: _____

Phone _____

Are you on a special diet? ☐ Yes ☐ No If yes, explain:

_____

_____

Do you have, or have you ever had, any of the following:

	YES	NO
1. Heart disease/Heart surgery	☐	☐
2. Kidney disease/Kidney surgery	☐	☐
3. High blood pressure/Hypertension	☐	☐
4. Diabetes	☐	☐
5. Gastric/Peptic ulcer	☐	☐
6. Asthma	☐	☐
7. Epilepsy	☐	☐
8. Sickle cell anaemia	☐	☐
9. HIV	☐	☐
10. Hepatitis	☐	☐
11. Cancer/Tumor/Groth	☐	☐
12. Radiotherapy/Chemotherapy	☐	☐
13. Any bleeding disorder	☐	☐

14. Any other: _____

_____

_____

_____

WOMEN

Are you pregnant or trying to get pregnant? ☐ Yes ☐ No

Taking Oral Contraceptives? ☐ Yes ☐ No

Nursing? ☐ Yes ☐ No

ALLERGIES

☐ Acrylic	☐ Codeine	☐ Metal
☐ Aspirin	☐ Latex	☐ Penicillin
☐ Barbiturates	☐ Local Anesthetics	☐ Sulfa

Other: _____

_____

List All prescription Drugs you currently take:

_____

_____

_____

_____

_____

_____

_____

List any Herbal Remedies, Multi-Vitamins, Supplements or Over the Counter Drugs you take more than 2X per week:

_____

_____

_____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my(patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

Signature of Patient, Parents or Guardian

_____

Date