West Richmond Dental Centre

PATIENT INFORMATION

*A Parent or Guardian will be responsible for decisions relating to my treatment: ☐ YES ☐ NO

Dr Mr Mrs Ms Name _____ Preferred Name _____

Address _____

City _____ Prov _____ Postal Code _____ E-mail _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Date of Birth _____/_____/_____ Sex ☐ Male ☐ Female SIN# _____
M D Y

Whom may we thank for referring you? _____

MEDICAL HISTORY (this information will remain confidential)

Medical Alerts _____

Physician _____ Phone ( ) _____

Are you now or have you recently been under treatment by a physician? ☐ Yes ☐ No

Reason _____

Have you ever been hospitalized or had a serious illness? ☐ Yes ☐ No

If yes, please explain _____

Are you taking any medication(s) including non-prescription medications? ☐ Yes ☐ No

If yes, please list _____

Are you taking any anticoagulants, blood thinners or aspirin? ☐ Yes ☐ No

Do you bruise easily or have prolonged bleeding? ☐ Yes ☐ No

Please list any allergies : _____

Are you allergic to or do you suffer ill effects from any of the following:

☐ Sulfa Drugs ☐ Local Anesthetics ☐ Penicillin or other antibiotics ☐ Barbituates (ie. Codeine)
☐ Sedatives ☐ Iodine ☐ Aspirin ☐ Latex Rubber ☐ Any Metals ☐ Other _____

Do you use tobacco? ☐ Yes ☐ No

Have you ever fainted, had shortness of breath or chest pains? ☐ Yes ☐ No

WOMEN ONLY: Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking oral contraceptives (pills, shots or implant)? ☐ Yes ☐ No

Are you taking estrogen therapy? ☐ Yes ☐ No

Do you have or have you had any of the following: (please circle)

AIDS/HIV +	Angina Pectoris	Arthritis /Rheumatic	Artificial Heart Valve
Artificial Joints	Asthma	Blood Disorders	Cancer
Circulation problems	Cortisone/Steroid	Diabetes	Epilepsy/Seizures
Glandular Disorders	Glaucoma	Heart Disease	Heart Attack
Heart Murmur	Pacemaker	Hepatitis A	Hepatitis B
Hepatitis C	Transplant	Implant	Radiation
Chemotherapy	Scarlet/Rheumatic Fever	Sinus problems	
Intestinal/Stomach problems	Stroke	Thyroid Disease	Tuberculosis
High/Low Blood Pressure	Kidney/Liver Disease	Malignant Hyperthermia/Organ Transplant	
Valve Disorder			

Do you consider yourself a nervous dental patient? ☐ Yes ☐ No

Have you used Nitrous Oxide (laughing gas) or sedation during dental visits? ☐ Yes ☐ No

What is the main reason for your visit today? _____

EMERGENCY CONTACT: Name _____ Phone ( ) _____

DENTAL HISTORY

What was the date of your last dental visit? _____ When was your last xray? _____

How often do you brush per day? _____ How often do you floss per day? _____

Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No

Do your gums feel swollen or tender? ☐ Yes ☐ No

Do you have bad breath or a bad taste in your mouth? ☐ Yes ☐ No

Does your jaw crack or pop when you open widely? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you have food catch between your teeth? ☐ Yes ☐ No

Have you ever had any problem with previous dental treatment? ☐ Yes ☐ No

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

GENERAL RELEASE

I, the undersigned, understand that the information contained in the **dental and medical history** portion of this chart is important to my treatment. I certify that all the information I have or will complete is/will be correct and that I will not knowingly omit data. I authorize this dental office to perform **diagnostic** procedures as may be required to determine necessary treatment. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. I understand that I am responsible for any fees on my account not paid by my dental plan, for both myself and my dependants. I authorize this office to submit **electronic claims** on my behalf, to my dental plan (if applicable).

Patient Signature _____ Date _____

WEST RICHMOND DENTAL CENTRE OFFICE POLICIES

A minimum of 24 hours notice is required to change or cancel a booked appointment. Otherwise a cancellation fee of $75 is charged to recover the costs of the missed appointment.

If you have a dental plan your portion that is not covered (co-payment) is due at the time of your appointment. If your dental plan sends money directly to you we ask that payment is made in full at the time of your appointment.

We require all new patients with dental insurance to complete our "dental insurance info" form in order to bill to your plan directly. Without this information we will be happy to bill to your plan however payment in full will be expected at the time services are rendered and you will be reimbursed by your insurance plan.

Any expenses incurred in your dental treatment which are not covered by your dental plan, will be billed directly to you. For your convenience credit card payments are available over the phone. 2% interest per month, 18% per annum will be added to delinquent accounts.

Dental Plans that do not follow the fees of the BC dental association or pay the member only will not be accepted in our office. We will be happy to bill the plan on your behalf and have your insurance company reimburse you directly.

Thank you for your consideration.

Patient Signature_____ Date_____

SUBMIT