WELCOME TO OUR PRACTICE

NEW PATIENT INFORMATION FORM

PORT
DENTAL HEALTH
& IMPLANT CENTRE

First Name: _____ Last Name: _____

Date of Birth: _____ Marital Status: _____

Personal Health Number (Care Card): _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

How do you prefer to be contacted? ☐ Cell ☐ Home Phone ☐ Email ☐ Work Phone:

Who do we call in case of emergency? Name: _____ Phone: _____

Who can we thank for referring you (how did you find out about our practice)?:

☐ Patient: _____ (Relationship) _____ ☐ Website

☐ Online / Google Search ☐ Newspaper Ad ☐ Walk by ☐ External Signage

☐ Social Media

Cancellation Policy

Please provide at least 2 full business days notice for any appointment changes or cancellations directly by phone during regular clinic hours. This allows us enough time to offer the appointment to a patient who is waiting for a visit and allows us to continue offering care to other patients in a timely manner. If less than 2 business days, a fee will apply.

Personal History

What is your primary concern today: _____

When did this become a concern: _____

How would you describe your last dental experience: _____

What prevented you from returning to your former Dentist?: _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Do you have or have you ever had ever have Braces, Orthodontics, Treatment or Upper Bite Adjustment?: ☐ Yes ☐ No

How often do you brush? _____

What type of toothbrush do you use: ☐ manual ☐ electric ☐ soft ☐ medium ☐ hard

How often are you flossing: _____

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Which method of flossing do you use? (Please circle all that apply) : String floss, floss piks, water pik, toothpicks, air flosser, proxybrush, rubber tip.

DENTAL HISTORY

Please answer Yes or No to the following:	YES	NO
Gum and Bone		
Do your gums bleed or are they painful when brushing or flossing?	☐	☐
Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
Is there anyone with a history of periodontal disease in your family?	☐	☐
Have you ever experienced gum recession?	☐	☐
Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
Tooth Structure		
Have you had any cavities within the past 2 years?	☐	☐
Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
Do you currently have any broken/chipped teeth, or a broken/missing filling?	☐	☐
Do you frequently get food caught between any teeth?	☐	☐
If yes, where?		
Do you have, or have you had a toothache in the last 6 months?	☐	☐
Smile Characteristics		
Is there anything about the appearance of your teeth that you would like to change?	☐	☐
Have you ever whitened (bleached) your teeth?	☐	☐
Would you like to whiten your teeth?	☐	☐
Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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MEDICAL HISTORY

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been instructed to take pre-medication prior to dental treatment? _____

Do You Have or Have You Ever Had:	YES	NO
1. hospitalization for illness or injury	☐	☐
If yes, please specify _____		
2. an allergic reaction to:		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa or sulfa drugs		
☐ anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems _____ (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. hypo or hyper thyroid _____	☐	☐
21. parathyroid disease _____	☐	☐
22. calcium deficiency _____	☐	☐
23. hormone deficiency _____	☐	☐
24. high cholesterol or taking statin drugs _____	☐	☐
25. diabetes (HbA1c = _____) _____	☐	☐
26. stomach or duodenal ulcer _____	☐	☐
27. digestive disorders _____ (i.e. celiac disease, gastric reflux)	☐	☐
28. osteoporosis/osteopenia _____ (i.e. taking bisphosphonates)	☐	☐
29. arthritis _____	☐	☐
30. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
31. glaucoma _____	☐	☐
32. contact lenses _____	☐	☐
33. head or neck injuries _____	☐	☐
34. epilepsy, convulsions (seizures) _____	☐	☐
35. neurologic disorders _____ (ADD/ADHD, prion disease)	☐	☐
36. viral infections and cold sores _____	☐	☐
37. any lumps or swelling in the mouth _____	☐	☐
38. hives, skin rash, hay fever _____	☐	☐
39. STI / STD / HPV _____	☐	☐
40. hepatitis (type _____) _____	☐	☐
41. HIV / AIDS _____	☐	☐
42. tumor, abnormal growth _____	☐	☐
43. radiation therapy _____	☐	☐
44. biphosphonates _____	☐	☐

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	YES	NO
45. cancer a) if yes, what type: _____	☐	☐
46. chemotherapy, immunosuppressive medication ____	☐	☐
47. emotional difficulties _____	☐	☐
48. psychiatric treatment _____	☐	☐
49. antidepressant medication _____	☐	☐
50. alcoholism / drug addiction _____	☐	☐
51. alcohol / recreational drug use _____ a) how many drinks per week? _____ b) type and frequency of recreational drugs _____ _____	☐	☐

Are You:

52. presently being treated for any other illness _____	☐	☐
53. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea)		
54. taking dietary supplements _____	☐	☐
55. often exhausted or fatigued _____	☐	☐
56. experiencing frequent headaches _____	☐	☐

	YES	NO
57. a tobacco user? _____ a) if yes, for how long and how much per day? _____ _____ b) have you smoked prevously? _____ c) when did you quit? _____	☐	☐
58. taking birth control pills _____	☐	☐
59. currently pregnant _____	☐	☐
60. currently breastfeeding _____	☐	☐
61. prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections).

_____

_____

_____

_____

_____

_____

_____

_____

List all medications, supplements, and or vitamins taken within the last two years.

Please advise us in the future of any change in your medical history or any medications you may be taking.

Drug	Purpose	Drug	Purpose

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

BP _____ **ASA** _____ **(1-6)**

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Privacy statement for patients and consent form

The privacy of our patients' personal information is important to us. We are committed to collecting, using, and disclosing personal information responsibly. Our office has established and implemented a variety of security measures to properly manage and safeguard your personal information from loss, theft and unauthorized access.

Personal information for our purposes is; information that is necessary for the provision of professional oral health care services, and information necessary to administer this dental practice. Personal information includes clinical records, x-rays, study models, photographs of your teeth, mouth, smile, face, and general health information obtained from a medial history review, insurance information, phones numbers and addresses. Clinical information, photographs and x-rays may be used for long-term follow-up and research purposes, as well as for education or teaching purposes.

Your personal information shall be disclosed only to those who have a need to know and specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include referring dentists, other dental specialists, physician(s), dental laboratories, and insurance carriers.

I give consent to share all records including personal/dental/medical information with the following family members:

1. _____

2. _____

3. _____

I certify that I have read and understand this document.

Printed name of patient /parent or guardian: _____

Signature of patient /parent or guardian: _____

Date: _____

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TAKE HOME

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Our team members pride ourselves on communication and therefore we have enclosed the following explanation regarding your dental benefits:

In order to support our patients, our team members will be happy to provide your insurance company with the forms they require to process your dental claim; we are not, however, responsible for amounts which your dental plan will not pay. Below are the guidelines set out by the BC Dental Association regarding dental insurance responsibilities.

Dentist's Responsibilities

Your dentist's main responsibility is to provide you with a standard of care that satisfies the expectations of their regulatory body, the College of Dental Surgeons of BC. In addition to providing treatment, your dentist and his or her staff will assist you with your insurance claim by:

1. Explaining your coverage using information from your plan booklet; and
2. Assisting you with the paperwork associated with your claim

Your dentist does not have a contract with any insurer to provide treatment; the contract is between you and your insurance company. The dentist just provides the service.

Patient's Responsibilities

Your dental plan is a contract between you and your insurance carrier. You, the patient, are responsible for educating yourself about such things as;

1. Procedures that are covered by your plan
2. To what extent or percentage of the actual cost they cover
3. Annual maximums in your plan

If you do not already have a booklet explaining your dental benefits, ask your employer for one and ask them to explain it to you. If necessary, take your booklet to your dental office where staff will be happy to help you understand your plan.

Many dental insurance carriers consider the details of your plan to be private since the Privacy Act was introduced in 2004 and will no longer release information about your plan to a dentist or dental staff.

Why is this important to you? If you have treatment and;

- There is no coverage under your plan contract; or
- Your coverage has run out because you have exceeded a limit of your plan; or
- Your dentist's fees for a procedure exceed the amount covered by your plan; or
- The coverage has expired you are responsible for payment for the treatment

Please also realize the office has no way of knowing if you have visited another dental office in the current year where you may have used part of your annual insurance limit.

For more information, go to *www.bcdental.org/Dental_Insurance*
Our administrative team will be happy to support you as much as possible.

Cancellation Policy

Out of respect for other patients, we require two full business days' notice for appointment cancellation or rescheduling to avoid a $50 charge to your account. Cancellations must be made by calling and speaking with a team member, not by email or voicemail please.

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First Name:_____ Last Name:_____CareCard#_____
Birthdate_____EMAIL:_____

Physician's Name/ #:_____ Patient Phone #:_____

Are you presently under a Physicians care:_____ If yes, what condition _____
_____.

What drugs/medication are you currently taking, including Aspirin

_____

Have you been hospitalized in the last 5 years? If yes, for what condition?_____

Do you have any allergies (eg. Latex,Penicillin)?_____
_____

Do you have any artificial body parts eg. Joints, pacemakers etc? _____

Do you have any infections we should be aware of? _____

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

	YES	NO		YES	NO
Hepatitis, jaundice, liver disease			Thyroid problems		
Rheumatic fever			Cancer or radiation therapy		
Heart Murmur			Taken bisphosphonates		
Heart Trouble			Glaucoma		
High or low blood pressure			Prolonged bleeding from a minor cut		
Liver problems			Have you had any other serious illnesses?		
Asthma or sinus problems			Do you smoke? (How much?)_____		
Diabetes			Do you have sleep apnea		
Arthritis or rheumatism			Are you a nervous patient?		
Stomach problems or ulcers			HIV / AIDS		
Tuberculosis or lung disease			WOMEN:		
Epilepsy or nervous problems			Are you pregnant?		
Cold Sores			Are you post menopause?		

DENTAL HISTORY :

***Chief Concern:*_____**

How often do you brush? _____ Do you use a hard or soft brush? _____

Do you use other dental aids (floss, toothpicks, mouthwash etc)? _____

How often do you have professional dental cleanings? _____

When was your last profession dental cleaning? _____

Do you or have you ever had….	**YES**	**NO**		**YES**	**NO**
Any injury to your face or jaw?			**Gum surgery?**		
Any pain in your face or jaw?			**Sore or sensitive teeth?**		
Bleeding gums?			**Teeth straightened?**		
Loose teeth?			**Clenched or grinded your teeth?**		
Bad breath?			**Freezing with your cleanings?**		

Date:_____Signature of Patient:_____Reviewed By:_____