

WELCOME TO OUR PRACTICE

NEW PATIENT INFORMATION FORM



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: _____

TREATING EVERYONE LIKE FAMILY

3633 3rd Avenue
Port Alberni, BC
V9Y 4E7

Phone: 250-724-6527
Fax: 250-724-6513
Email: admin@portdental.com
www.portdental.com

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 _____

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

- 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 _____

- YES NO**
57. a tobacco user? _____
 a) if yes, for how long and how much per day? _____

 b) have you smoked previously? _____
 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).

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 _____

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)

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: _____

TAKE HOME



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.