COURTENAY DentalHealth & IMPLANT CENTRE
101, 389 - 12th Street
Courtenay, BC V9N BV7

NEW PATIENT FORM

Full Name:	**Birthdate:**	**Care card #:**
Address:		**Postal Code:**
Cell Phone:	**Home Phone:**	**Preferred Pronoun:**
Emergency Contact:	**Relationship:**	**Phone:**
Email:	**Physician's Name:**	**Phone:**

Do you have dental insurance? If yes, please notify reception:

Who can we thank for referring you?

Online/Google **Newspaper Ad** **Walk by** **Social Media** **Website**

Are you presently under a Physician's care for chronic medical conditions?

What drugs/medications are you currently taking (including Aspirin and Vitamins)? *If you cannot remember, we can call your pharmacy*

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

Do you have any allergies (e.g. Latex, Penicillin?)

Do you require PRE-MEDICATION FOR ANY DENTAL APPOINTMENTS?

Do you have any artificial body parts (e.g. Heart valve, Joints, Pacemaker)?

Do you have any infections we should be aware of?

MEDICAL HISTORY

Do you have or have you had any of the following: (It is important that you answer accurately)

	YES	NO		YES	NO
Heart conditions (including heart attack)			Osteoporosis/ osteopenia or have taken bisphosphonates		
History of infective endocarditis			Hepatitis (A, B or C)		
History of stroke			Cancer/ radiation or chemotherapy/ tumor		
High or low blood pressure			Thyroid problems		
Diabetes (Type __) A1C _____ Date_____			Prolonged bleeding from a minor cut		
Lung problems (COPD, emphysema)			Neurologic disorders (ADD/ADHD etc.)		
Asthma or sinus problems			Mental health disorders		
Liver disease or jaundice			Do you identify as a person with a disability?		
Kidney disease			Frequent headaches		
Stomach problems or ulcers			Sleep apnea or other sleeping issues		
Tuberculosis, chicken pox, measles			Use alcohol or other recreational drugs (including marijuana)		
Epilepsy or nervous problems			If yes, did you use in the last 24 hours?		
Arthritis			Do you smoke cigarettes? How much? _____		
Digestive disorders (Celiac, acid reflux)			WOMEN:		
Blood disorders (Anemia etc.)					
Autoimmune diseases (Lupus etc.)			Are you pregnant?		
HIV/AIDS			Are you nursing?		
Cold sores/viral infections (STI/ HPV)			Are you post menopause?		

Any other concerns to note that are not mentioned above?

Date: **Signature of Patient:** **Reviewed By:**

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DENTAL HISTORY

It is important to us that we meet your needs and address your primary concerns, therefore we ask that you share the following information leading into your appointment today:

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 3mths_____ 4mths_____ 6mths_____ 12mths_____ not routinely_____

How often do you brush? _____ Do you use a manual or electric toothbrush? _____

How often do you floss? _____ Do you use any other oral hygiene aids? _____

Please answer YES or NO to the following questions

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 injury), or do you have difficulty eating an apple? _____

Have you had freezing with dental cleanings in the past? _____

TOOTH STRUCTURE

Do you have any pain, swelling, or lumps in your mouth? _____

Have you ever had any cavities within the past 3 years? _____

Are any teeth sensitive to hot, cold, biting sweets, or do you avoid brushing any part of your mouth? _____

Have you ever broken teeth, chipped teeth, had a toothache or cracked filling? _____

Have you ever had injury to your face or jaw? _____

Do you frequently get food caught between your teeth? _____

Do you experience bad breath? _____

Do you clench or grind your teeth? If yes, do you wear a night guard? _____

Do you or have you ever had Braces, Orthodontics Treatment, or Upper Bite Adjustment? _____

SMILE CHARACTERISTICS

On a scale of 1 – 10 how would you rate your smile? _____

What would help to make it a 10?_____

Have you ever whitened (bleached) your teeth? _____

Have you or do you ever feel uncomfortable or self-conscious about the appearance of your teeth? _____

Have you ever been disappointed with the appearance of previous dental work? _____

Patient's signature_____

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Office Financial Agreement

Our mission at Courtenay Dental Health and Implant Centre is to provide excellence in dentistry that meets your individual needs. In order to reduce the cost of providing dentistry to our patients, **payment is expected at the time of service.**

We are pleased to offer the following payment options:

___ Option # 1 **Non Assignment of benefits or NO INSURANCE with payment in full**

Payment is made in full by cash, debit, Visa or MasterCard at the time of treatment.

___ Option # 2 **Assignment of Benefits**

Our office will accept an assignment of benefits from your insurance company with the understanding that the agreement regarding your benefits is between you, your employer and the insurance company.

The office completes and submits claims on your behalf as a courtesy, in an effort to save you time.

We will provide your insurance company with the forms they require to process your dental claim, BUT

- We do not accept responsibility for the outcome of the claim or for the amounts which your dental plan will not pay. This includes but is not limited to:
    - Procedures that are covered by your plan
    - To what extent or percentage of the actual cost they cover
    - Annual maximums set out by your plan
- We need you to understand that this does not eliminate your financial obligation for your treatment.
- We DO NOT guarantee payment from your insurance company and if your claim is denied you will be responsible for the full amount at that time.
- We require you to pay the estimated amount NOT covered by your insurance company at the time of the service. This amount is only an estimate of charges and may be found to be insufficient after review for your insurance company.
- Our office WILL NOT enter into dispute with your insurance company over any claim, We will cooperate with any requests made from your insurance company but it is ultimately YOUR RESPONSIBILITY to resolve the dispute over payments made or not made by your insurance company to our practice.

I hereby assign payment of my primary dental benefits directly to Courtenay Dental Health and Implant Centre.

Date_____ Name_____

Signature_____

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Your Privacy is Always Assured

Privacy of our patient's personal information is important to us. Personal information is necessary for providing services to you and information may be necessary to administer your dental treatment.

I authorize communication of this personal information by mail, electronic mail, and verbal means. Personal information includes clinical records, xrays, study models, photographs of you and your teeth, mouth, smile and face, and general information obtained from a medical history review, insurance information, phone numbers, and email addresses. Clinical information, photographs, and xrays may also be used for long term follow up and research purposes, as well as for education or teaching purposes.

Your personal information will only be shared with those who have a need to know and specific information disclosed shall be restricted to only the information relevant to the recipients need to know. Those who have a need to know include referring dentists, other dental specialists, physicians, 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 understand this document.

Patient/Parent or Guardian Signature_____

Date _____