Cowichan Valley
Dental Health & Implant Centre

Welcome To Our Practice

NEW PATIENT INFORMATION

First Name: _____ Last Name: _____ Preferred Name: _____

Gender: _____ Birthday [MM/DD/YYYY]: _____ Care Card Number: _____

Mailing Address: _____ City/Town: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Preferred contact [circle]: Home Work Cell Email

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

How did you hear about our practice? ☐ Patient [let us know who to thank]: _____

☐ Website ☐ Online / Google Search ☐ News Paper Ad ☐ Walk by ☐ External Signage ☐ Social Media

Name of Family Doctor & Clinic Name: _____

DENTAL HISTORY

It is important to us that we meet your needs and address any dental concerns you may have. Please help us by answering the following regarding your visit:

Are you currently experiencing any pain, or hot/cold or pressure sensitivity? _____

What is your chief concern? _____

Do you experience dental anxiety? [Circle one]: Yes No If yes, have you required sedation in the past? [Circle one]: Yes No

I routinely see my dentist every [circle one]: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

Teeth & Gums [PLEASE CIRCLE YES [Y] OR NO [N] TO THE FOLLOWING]	**YES**	**NO**
Is there is a history of periodontal disease in your family?	Y	N
Do your gums bleed, or do experience any pain while brushing or flossing?	Y	N
Have you ever been treated for gum disease or been told you have loss bone around your teeth?	Y	N
Have you ever experienced gum recession?	Y	N
Have you had any cavities filled within the last 3 years?	Y	N
Do you have a history of broken and/or chipped teeth, or cracking fillings?	Y	N
Do you frequently get food caught between any teeth?	Y	N
Have you had orthodontic treatment [braces, spacers, etc.] in the past?	Y	N
Have you ever wanted to change the appearance of your teeth?	Y	N
Do you currently, or have you previously used whitening treatment?	Y	N

INSURANCE INFORMATION

If you are covered through **First Nations Health Authority, please provide your Status number: _____

Primary Insurance: Policy Holder: _____ Birthdate [MM/DD/YYYY]: _____

Insurance Company: _____ Group/Plan/Policy No. _____ ID/Certificate No. _____

Secondary Insurance: Policy Holder: _____ Birthdate [MM/DD/YYYY]: _____

Insurance Company: _____ Group/Plan/Policy No. _____ ID/Certificate No. _____

Disclaimer **Dental benefits are not determined by the dental office.** Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services, but please note that when we submit to your insurance, it is not a guarantee of payment by the plan and costs may vary to your individual plan once submitted. Any treatment plan proposed to you is **an estimate** of what your coverage will be and is **not a guarantee** of payment**.** If you require exact costs prior to treatment, please allow **6-8 weeks prior to treatment** for us to submit a pre-determination to the insurance company. Regardless of what the dental plan pays, you are responsible for all costs unpaid by the insurance provider. Details of your plan are available to you by contacting the insurance company directly.

I accept full responsibility for my account at Cowichan Valley Dental & recognize that it is my responsibility to be aware of the details of my dental insurance plan, if applicable.

Please Initial: _____

PRIVACY DISCLOSURE

Your Privacy is Always Assured

Respecting privacy is an extremely important part of our office providing you with quality dental care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing personal information responsibly; it is important to us to provide this service to our patients.

Our office frequently coordinates patient care with other dental offices, specialty practices, labs, etc. in order to optimize treatment. In these cases, we would forward both personal and medical information, including contact and insurance details, as well as any relevant medical history. In some cases, we would need to include dental history, radiographs, study models and photos from your chart as well. The methods of transfer range from verbal, electronic, Canada Post or courier depending on other office preferences.

All of our staff members are aware of the sensitive nature of retrieving and transferring patient information and are aware to share information only where and when it is appropriate and necessary.

I certify that I have read and understand this document and approve the transfer of my records as needed and assume full responsibility of my account with Cowichan Valley Dental.

Patient Name [Printed]: _____ Date [MM/DD/YYYY]: _____

Signature of Patient OR Parent/Guardian: _____

MEDICAL HISTORY

Have you been hospitalized for illness or injury? Y__ N __ If yes, please specify what/when:_____

**Do you have any allergies [circle one]? Yes No Please list ALL allergies [seasonal, food, metals, medications, etc.]:

_____

Do you smoke? Yes ___ No ___ How much? _____ | Do you consume alcohol? Yes ___ No ___ How often? _____

Please list all medications taken within the last TWO years:

MEDICATION: _____ **FOR:** _____
MEDICATION: _____ **FOR:** _____
MEDICATION: _____ **FOR:** _____
MEDICATION: _____ **FOR:** _____
MEDICATION: _____ **FOR:** _____
MEDICATION: _____ **FOR:** _____

Any additional medications: _____

** **Do you require a pre-medication [antibiotic] prior to dental treatment? Yes _____ No _____**

Please *check yes or no* to ALL of the following you have or have had in the past:

Y	N		Y	N	
O	O	Addiction: Drug ____ Treatment? **Y N**	O	O	Heart Murmur
O	O	ADD/ADHD	O	O	Hepatitis [please check]: **A ___ B ___ C ___**
O	O	Anemia	O	O	High Blood Pressure
O	O	Anxiety/Depression	O	O	High Cholesterol
O	O	Asthma	O	O	History of Infective Endocarditis
O	O	Arthritis	O	O	HIV/Aids
O	O	Artificial Joints: _____	O	O	Irregular Heartbeat
O	O	Artificial Heart Valve	O	O	Kidney Disease
O	O	Autism	O	O	Liver Disease
O	O	Bleeding/Clotting Disorder	O	O	Low Blood Pressure
O	O	Blood Disease	O	O	Mental or Neurological Disorders [specify]: _____
O	O	Bone disease: Bisphosphonates? **Y N**			_____
O	O	Cancer – Type & Treatment: _____	O	O	Nervous about dental treatment
		_____	O	O	Osteoporosis
O	O	Chronic Cough	O	O	Pacemaker/Implanted Defibrillator
O	O	Congestive Heart Failure	O	O	Pregnant or Breast feeding [currently]
O	O	COPD	O	O	Psychiatric Treatment
O	O	Coronary Artery Disease	O	O	Radiation Therapy
O	O	Diabetes [please check]: **Type I ____ Type II ____**	O	O	Rheumatic Fever
O	O	Emphysema/Shortness of Breath/Trouble Breathing	O	O	Skin Disease: Please specify _____
O	O	Epilepsy/Seizures	O	O	Sleep Apnea: Do you have a device? **Y N**
O	O	Headaches	O	O	Stroke
O	O	Hearing Impaired. Hearing Aids? **Y N**	O	O	Thyroid Disease
O	O	Heart Attack – When? _____	O	O	Vision Impaired
			O	O	Vascular Disease

If you have any conditions, including auto-immune disorders, not listed above, please specify: _____

_____

Patient Name [Printed]: _____ **Date [MM/DD/YYYY]:** _____

Signature of Patient OR Parent/Guardian: _____ **Doctor's Signature:** _____