STUDIO B DENTAL

General | Cosmetic | Implant | Sleep Dentistry

Getting to know you better

☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr First Name:_____ Last Name:_____

Preferred Name: _____ Date of Birth: _____(dd/mm/yy) ☐ Male ☐ Female

Address: _____ Apt/Unit#:_____

City: _____ Province:_____ Postal Code: _____ Phone #:_____

Work #:_____ ext. _____ Cell #:_____ E-mail:_____

Employer: _____ Position: _____

Do you have any insurance benefits we can help you maximize? ☐ Yes ☐ No

Family Members at our practice:_____

Best way to contact you: ☐ Home Number ☐ Work Number ☐ E-mail ☐ Cell Number

☐ M ☐ T ☐ W ☐ T ☐ F ☐ am ☐ pm

In case of an emergency – Please notify_____ Phone Number:_____

My Favourite: Travel Destination:_____ Music:_____ Sport & Team:_____

Movie:_____ Hobby:_____

How did you hear about us? (Check all that apply) Friend/Relative's name:_____

☐ Flyer ☐ Radio ☐ Front Sign ☐ Internet - Keywords Typed:_____ ☐ Other_____

Please check any of the following problems that may apply to you.

☐ Sensitivity (hot, cold, sweet)
☐ Jaw joint pain (clicking/cracking)
☐ Bleeding, swollen or irritated gums
☐ Loose/Poor fitting dentures
☐ Tooth pain or discomfort while chewing
☐ Teeth or fillings breaking
☐ Loose, tipped or shifting teeth
☐ Wears dentures
☐ Headaches, earaches, neck pain
☐ Grinding or clenching teeth
☐ Bad breath or bad taste in your mouth
☐ Previous orthodontics or gum surgery

Please share the following dates:

Last dental cleaning _____ Last oral cancer screening _____ Last X-Rays_____

☐ Yes ☐ No If you could whiten your teeth for a cost anyone could afford, would you do it?
☐ Yes ☐ No Have you ever smoked? If yes, how many years?_____ Do you currently smoke? ☐ Yes ☐ No
☐ Yes ☐ No Are you nervous during dental treatment?
☐ Yes ☐ No I would be interested in different sedation options to make my visits more relaxing?
☐ Yes ☐ No Do you wish to speak privately to the doctor about any problem or medical condition?

If I could improve my oral health, I would...

☐ Make my teeth brighter
☐ Close spaces
☐ Replace missing teeth
☐ Have a smile makeover
☐ Make my teeth straighter
☐ Repair chipped teeth
☐ Replace old crowns that don't match
☐ Replace black metal fillings with natural, tooth coloured fillings

One a scale of 1 (low) to 10 (high)...

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

How would you rate the look & feel of your smile?
1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?_____

What, if anything, has kept you from having dental treatment?_____

What is the most important thing to you about your smile and dental health?_____

What is the most important thing to you about your first visit / today's visit?_____

Dental, Medical & Insurance

Please check any of the following that apply to you:

☐ AIDS	☐ Drug addiction	☐ HIV positive	☐ Respiratory problems	☐ Allergies	☐ Emphysema
☐ Rheumatic fever	☐ Anemia	☐ Excessive bleeding	☐ Dizziness	☐ Arthritis	☐ Fainting
☐ Jaw joint pain	☐ Scarlet fever	☐ Glaucoma	☐ Artificial heart valve	☐ Kidney disease	☐ Seizures
☐ Artificial joints	☐ Heart conditions	☐ Blood disease	☐ Asthma	☐ Pregnant currently	☐ Heart murmur
☐ Snoring/Sleep apnea	☐ Pacemaker	☐ Stroke	☐ Bruise easily	☐ Heart surgery	☐ Thyroid disease
☐ Cancer	☐ Hepatitis A/B/C	☐ Tuberculosis	☐ Chemotherapy	☐ Diabetes	☐ Phen fen (1 month+)
☐ HI/LO blood pressure	☐ Mitral valve prolapse	☐ Venereal diseases	☐ Nervousness/Depression	☐ Liver disease/jaundice	☐ Radiation
☐ Heart lesions, congenital	☐ Ulcers/Stomach problems		☐ Other_____		

Do you have any of the following allergies?

☐ Aspirin	☐ Codeine	☐ Darvon	☐ Percodan	☐ Latex
☐ Local anesthetic	☐ Penicillin	☐ Sulpha	☐ Other _____	

☐ Yes ☐ No Have you ever had a joint replacement? If yes, when?_____

☐ Yes ☐ No Has your physician ever told you to take antibiotics prior to dental procedures?
If so, why?_____

☐ Yes ☐ No Have you ever experienced complications following a medical or dental procedure?
If yes, please describe?_____

☐ Yes ☐ No Is there anything else you think we should know regarding your medical history?
If yes, please describe?_____

☐ Yes ☐ No Are you currently under a physician's care?
If yes, what for?_____

☐ Yes ☐ No Are you taking any medications/supplements?
If yes, please specify_____

Medications

Name:_____ Name:_____ Name:_____
Reason:_____ Reason:_____ Reason:_____
Dosage:_____ Dosage:_____ Dosage:_____

Family Physician's Name:_____Physician's Phone Number: _____

How healthy would you like your teeth to be? ☐ The best it can be ☐ Average ☐ Don't really care
What quality of dentistry do you want us to recommend? ☐ Ideal/The best ☐ Average ☐ Just patch it up

Privacy Information

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information
I agree that Village Dental Centre has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Signature: _____Date: _____

I the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Village Dental Centre all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____