

PATIENT INFORMATION (Confidential)



First Name _____ Last Name _____ Birth date _____
 Address _____ City _____ Prov _____ Postal Code _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Employer _____ Marital Status _____
 E-mail _____ Gender _____
 Emergency Contact/Parent Contact _____ Phone # _____

1. Relationship to patient: _____
2. Is there anyone else in your household that is a patient here? _____
 If yes please list _____
3. Are you a student (University /College student)? _____
 If yes please name school: _____

WOMEN ONLY:

4. Are you pregnant? _____
 If Yes when is the due date? _____
5. What is your primary reason for booking the appointment today? _____
6. How would you prefer your appointment reminders? Email Phone Call Text
7. How did you hear about us? Family/Friend Website Internet/Google Facebook Other
 If you selected Family/Friend or other, whom shall we thank for your referral? _____
8. Would you like to be direct billed? Yes No
9. Do you have dental insurance? Yes No

PRIMARY INSURANCE POLICY



Insurance Company _____ Policy # _____
 Sub ID # _____
 Policyholder's Name _____
 Policyholder's Date of Birth _____
 Place of Employment _____ Work Phone _____

SECONDARY INSURANCE POLICY



Insurance Company _____ Policy # _____
 Sub ID # _____
 Policyholder's Name _____
 Policyholder's Date of Birth _____
 Place of Employment _____ Work Phone _____

CREDIT CARD AUTHORIZATION



Our office will gladly direct bill your insurance company on your behalf. In order to direct bill your insurance company, we kindly ask that you leave an imprint of your credit card and any amounts not covered by your insurance company will be charged to your credit card and an email receipt sent. Please advise us of any future changes in your credit card.

I authorize Chinook Village Dental to process invoice charges to my:

Visa Mastercard Debit

Credit Card #: _____

Expiry Date: _____

Patient(s) on Account: _____

Name(s) of Patient That The Credit Card is Authorized For: _____

Cardholder First Name: _____ Cardholder Last Name _____

Cardholder E-mail Address: _____

Cardholder Signature: _____

Date: _____

The balance remaining after we have received your insurance benefits, will be charged to your credit card. This authorization will be in effect until notice of cancellation is forwarded in writing to Chinook Village Dental.

MEDICAL HISTORY



Physician _____ Physician's Office Phone _____

8. Date of Last Medical Exam _____

9. Are you currently under any medical treatment? Yes No

10. Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

11. Are you currently taking any medications, including over the counter medications? _____

Please list: _____

12. Do you have or have had any of the following? Please check all that apply.

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Head/Neck/Jaw Injuries | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease/Angina | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Osteoporosis Medications |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> None Of These |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Respiratory Problems | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Rheumatic Fever | |

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

MEDICAL HISTORY



13. Are there any conditions or diseases not listed above that you have or ever had?

YES NO

If yes, please explain: _____

14. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease) If yes, please explain: _____

YES NO

15. Do you have a history of snoring/sleep apnea? _____

YES NO

If so do you use a CPAP machine? _____

YES NO

16. Do you often find it difficult to breathe through your nose? _____

YES NO

17. Do you have any allergies to medications? _____

YES NO

If yes please list: _____

DENTAL HISTORY



18. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

YES NO

19. Have you had an unfavorable dental experience or complications following dental treatment? _____

YES NO

20. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____

YES NO

21. Did you ever have braces, or orthodontic treatment. _____

YES NO

Check All That Apply *

- Gums bleed while you brush
- Your teeth are sensitive to hot or cold liquid/foods
- You feel pain in any of your teeth
- Have any sores/lumps in your mouth

- You bite your lips or cheeks frequently
- Had any difficult extractions or prolonged bleeding from it in the past
- You wear dentures or partials
- none

BITE AND JAW JOINT



22. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____

YES NO

23. Do you have any problems with sleep (i.e. restlessness), or wake up with a headache or an awareness of your teeth? _____

YES NO

24. Do you wear or have you ever worn a bite appliance or nightguard? _____

YES NO

25. Do you feel that you clench or grind your teeth? _____

YES NO

SMILE CHARACTERISTICS



26. Is there anything about the appearance of your teeth or smile that you would like to change, or felt uncomfortable/self conscious about? _____

YES NO

27. Have you ever whitened (bleached) your teeth? _____

YES NO

CONSENT FOR SERVICES



I, the undersigned, also certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care.

I agree to pay value of said services which shall be as billed, unless objected to by me, in writing, within the time for payment thereof. I agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand my personal information disclosed is protected by the Privacy Act. I agree that Chinook Village Dental can electronically file dental claims on my behalf.

I have read the above conditions of treatment and payment and agree to their content.

Signature _____ Date _____