KOOTENAY LIFE DENTAL

PATIENT INFORMATION

Date: _____

Name: (last)_____ (first)_____ (preferred)_____
Address: _____
City: _____ **Province/State:** _____ **Postal/Zip Code**: _____
Birthdate (mm/dd/yr):_____ **Health Care Number**:_____ **Employer**:_____
Phone Number: (home)_____ (cell)_____ (work)_____
Gender: Male ☐ Female ☐ **Marital Status**: Married ☐ Separated ☐ Divorced ☐ Single ☐ Widow ☐ Common law ☐
Are you covered by a dental insurance plan? Yes ☐ No ☐ **Email**: _____

DENTAL INFORMATION

	Yes	No
Is your mouth dry?	☐	☐
Are your teeth sensitive to hot or cold?	☐	☐
Do you have frequent headaches?	☐	☐
Have you had any problems with dental freezing?	☐	☐
Do you have clicking, popping or discomfort in the jaw?	☐	☐
Do you grind your teeth/ or wear an appliance?	☐	☐
Are you currently feeling any discomfort?	☐	☐
Are you nervous or anxious about dental treatment?	☐	☐

How often do you floss? _____
How often do you brush? _____
Date of last dental visit? _____
Date of last hygiene visit? _____
Any additional dental information:_____
_____
_____
_____

MEDICAL INFORMATION

Physician's Name: _____
Date of your last annual medical exam: _____

	Yes	No
Are you taking any antibiotics?	☐	☐
Are you taking any anticoagulants (blood thinners)?	☐	☐
Are you taking Aspirin, Aleve, or Ibuprofen daily?	☐	☐
Are you taking High Blood Pressure medication?	☐	☐
Are you taking Insulin or other diabetic drugs?	☐	☐
Do you have a drug or alcohol addiction?	☐	☐
Have you had any major surgeries?	☐	☐

	Yes	No
Are you / have you taken any Bisphosphonate drugs (for osteoporosis or chemotherapy)?	☐	☐
Have you been hospitalized in the last 5 years?	☐	☐
Reason: _____		
_____		
Are you taking any other medications?	☐	☐
If yes, please list: _____		
_____		
_____		

ALLERGIES AND HEALTH HISTORY

☐**Aspirin** ☐ **Codeine** ☐**Sulfa** ☐ **Local Anesthetic** ☐ **Advil** ☐**Penicillin** ☐ **LATEX** ☐**Seasonal** ☐**Metals**
Other Allergies (please list): _____
_____
Name of pharmacy: _____ **Town/City:** _____
Are you a Cannabis or Tobacco user? Yes☐ No☐ **WOMEN ONLY: Are you pregnant or nursing?** Yes☐ No☐
How often do you use? And which one? _____ **How many weeks pregnant?** _____
Are you taking oral contraceptives? Yes ☐ No ☐
Emergency Contact Information:(name/phone number)_____

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HEALTH HISTORY

Do you require antibiotics prior to dental treatment? Yes ☐ No ☐

	Yes	No		Yes	No
Acid Reflux	☐	☐	**HIV Positive**	☐	☐
Anemia	☐	☐	**Joint Replacement- When:**	☐	☐
Arthritis, Rheumatism	☐	☐	**Kidney Disease**	☐	☐
Artificial Heart Valve	☐	☐	**Liver Disease**	☐	☐
Asthma	☐	☐	**Low Blood Pressure**	☐	☐
Autism	☐	☐	**Lupus**	☐	☐
Abnormal Bleeding with Surgery	☐	☐	**Mental/Physical Disability:**	☐	☐
Cancer- Type:	☐	☐	**Migraines**	☐	☐
When:			**Mitral Valve Prolapse**	☐	☐
Diabetes- Type:	☐	☐	**Multiple Sclerosis**	☐	☐
Eating Disorder	☐	☐	**Osteoporosis**	☐	☐
Emphysema	☐	☐	**Pacemaker**	☐	☐
Epilepsy	☐	☐	**Psychiatric Care**	☐	☐
Fainting or Dizziness	☐	☐	**Respiratory/Lung Disease**	☐	☐
Fibromyalgia	☐	☐	**Rheumatic Fever**	☐	☐
Gastro Intestinal Disease (Eg: Crohns, IBS)	☐	☐	**Shortness of Breath**	☐	☐
Glaucoma	☐	☐	**Sexually Transmitted Infection**	☐	☐
Heart Attack- When:	☐	☐	**Skin Rash/Eczema/Psoriasis**	☐	☐
Heart Murmur	☐	☐	**Stroke- When:**	☐	☐
Heart Problems	☐	☐	**Thyroid Problems**	☐	☐
Hepatitis- Type:	☐	☐	**Other:**		
High Blood Pressure	☐	☐			

Do you have any disease, condition or problem you wish to speak to the doctor about privately? ☐ ☐

OFFICE POLICY PRIVACY AND CONSENT FOR SERVICES

All professional services must be paid for by cash, or acceptable credit/debit card at the time each service is performed. No exception. An estimate of treatment costs will be given to all patients with a treatment plan. This is ONLY AN ESTIMATE. Final costs for services may be higher or lower.

Patients with dental insurance understand that all dental services are charged directly to your insurance and you are responsible for the balance at the time of service.

It is YOUR benefit plan, therefore it is your responsibility to: Understand that some procedure codes may not be eligible under your benefit plan contract, fully understand and review your pre-determination, check annual maximum and deductible and expiry date of the pre-determination, provide our office with your pre-determination if more information is required and inform our office of any changes to your dental plan and / or employment, be aware that your benefits may be affected if you are entitled to benefits under any other plan.

If you wish to cancel an appointment you must give a minimum of 24 hour notice, otherwise you will be charged professional time lost. I authorize the communication of information related to treatment and to the coverage of services described in all forms to my general dentist. I also authorize release of information contained in my claim forms to my insured company/ plan administrator.

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

Signature: _____ **Date:** _____

Signature of patient, parent or guardian **(mm/dd/yr)**