vernon DENTAL CENTRE

NEW PATIENT INFORMATION

Name: _____ Date of Birth: m____ /d____ /y____ Todays Date: m___/d___/y___

Male ☐ Female ☐

Address: _____Postal Code: _____

Employer: _____ Emergency Contact: _____

Email: _____ Cell: _____

How may we remind you of your future appointments? Text ☐ Email ☐

Who may we thank for referring you? _____

Do you have Dental Insurance? Yes ☐ No ☐ If Yes, please bring your card to your appointment. Please note that it is your responsibility to know the details of your dental insurance.

Reason for your visit today: _____

Do you have any specific concerns? _____

What are you expecting to have done today? _____

Medical History

Have you ever had any of the following? Please check those that apply:

- ☐ Acid Reflux
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Birth Control
- ☐ Bisphosphonates
- ☐ Blood Disease/Disorders
- ☐ Cancer Type: _____
- ☐ Codeine Allergy
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Valve Replaced
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Pregnancy: Due date ____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Viral Infections
- ☐ Other:_____

- Have you had any health problems in the last five years? Yes ☐ No ☐
- My Current Medical Health is: Good ☐ Fair ☐ Poor ☐
- Physicians Name:_____
- Please list any drugs/ medications that you are taking (If there are more than five, we will ask for a copy from your pharmacy.): _____
- Do you Smoke? Yes ☐ No ☐ How much per day? _____
- Have you ever had any metal rods pins implants or prosthetic joints placed? Yes ☐ No ☐ When?_____
- Do you have any Allergies? Please list: _____

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Dental History

- (I feel) My Current Dental Health is — Good ☐ Fair ☐ Poor ☐
- Do you require antibiotics before dental treatment? — Yes ☐ No ☐
- Do your gums bleed? — Yes ☐ No ☐
- Are your teeth sensitive to heat, cold, or anything else? — Yes ☐ No ☐
- Do you presently, or have you ever had pain/discomfort in your jaw joint? (TMJ) — Yes ☐ No ☐
- Do you think, or have you ever been told your grind your teeth? — Yes ☐ No ☐
- How many times do you: floss/week? _____ brush/day? _____
- When was your last cavity? _____
- Is there anything that you would like to change about your smile? _____
- Have you ever had any problems with previous dental work?_____
- Have you ever had any unfavorable dental experiences? _____
- When was your last dental cleaning? _____
- When was your last dental visit? _____
- Have you had dental x-rays taken within the past year? Yes ☐ No ☐ If yes, please inform us if you would like us to contact your previous dental office to obtain these records.
- Why did you leave your previous dentist? (How can we make your experience better?)

  _____
- Please rate your smile 1-10. 1 2 3 4 5 6 7 8 9 10

Here at the Vernon Dental Centre, we offer a wide variety of services to enhance and keep your smile beautiful. Please circle any services below that you would like our friendly staff to discuss with you during your visit.

Zoom Tooth Whitening	Veneer	Invisalign
Traditional Orthodontics (brackets)	Smile Makeover	Bonding
Sealants	Crowns/ Bridges	Implants
Partials/ Dentures	Night/Sport Guards	

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

Signature: _____ Date: _____

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Financial Agreement

Our goal is provide the highest quality of dental care possible and to have clear communication of our financial policy.

All accounts are due and payable at time of service. If a procedure requires multiple appointments, payment is due in full at the first appointment.

Payment Options:

1. Cash
2. MasterCard
3. Visa
4. Credit card authorization for recurring charges:
    a. Treatment exceeds $500
    b. Plan may not exceed three months
        i. Orthodontics / Invisalign are the exceptions

Patients with insurance: The patient is responsible for the estimated non-covered portion, procedures and/or deductibles at the time of the service, OR the patient can sign a credit card authorization to bill their credit card after the insurance has paid for the visit. If the insurance company does not pay after 60 days, we will bill you directly for the balance. Please understand that just because you have 100% coverage, does not mean that your insurance will cover all procedures 100%. Ex: a white filling on a back tooth may only be covered for what the insurance company may pay for an amalgam filling.

Do we have permission to contact your insurance company on your behalf? Yes ☐ No ☐

Parents not accompanying their child to an appointment must make prior arrangements for payment (cash or credit card authorization).

Parents accompanying their children are financially responsible for payment.

Interest is charged for any unpaid balance.

Because instruments, chairs, and personnel are reserved for your appointment, there is a **$50 CHARGE FOR MISSED APPOINTMENTS.**

I assume responsibility to know all details of my dental insurance, including plan maximums.

I, _____, agree to these financial terms.

Signature _____ Date _____