

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:

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

- 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: _____

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: _____



The Vernon Dental Centre is committed to provide the highest quality care possible and entrust our patients to make informed decisions for their treatment by presenting and discussing all options verbally and in writing.

To optimise the patient's experience, Vernon Dental Centre reserves clinic resources for the date and time arranged with the patient. If, for any reason, you need to reschedule the appointment time reserved for you please notify us at least 2 days in advance so that another patient's needs can be accommodated. If a patient does not present for their reserved appointment, or gives less than 48 hours notice, the patient understands and agrees to pay a nominal fee charged by The Vernon Dental Centre at their discretion.

All fees for service are invoiced and payable at the time treatment is rendered. When extensive treatment is prescribed or recommended, such as orthodontic treatment or major restorations (crown and bridge, implants, etc.) a payment plan may be arranged by the patient prior to commencing treatment.

Upon accepting treatment, Vernon Dental Centre will provide a written Informed Consent form setting out the treatment to be provided, applicable fees and payment plan for the patient's approval.

Payment options currently include:

1. Cash
2. Credit card (MasterCard and Visa), which may include preauthorization for installments when billings exceed will or are likely to exceed \$500.
3. Debit card
4. Electronic/Interac bank transfer

Minor children (under 18 years of age) should be accompanied by their parent or legal guardian at their appointment to ensure prescribed and recommended treatment is understood and authorized by a responsible adult. If a minor child is not accompanied by a parent or legal guardian, Vernon Dental Centre should be informed prior to the child's appointment so appropriate arrangements can be made regarding treatment and payment of fees for services performed.

In support of our patients with Extended Health Benefits which include dental services, The Vernon Dental Centre will prepare your claim form and submit to your insurance company electronically. Most patients receive reimbursement, based upon their plan's coverage and limitations, within 7 business days of claim submission. We encourage all patients to familiarize themselves with the coverage and limitations in their plan and contact their provider directly if they have questions or need further information about their coverage or reimbursement.

I _____ have read, understand, and agree to abide by these policies.

Signature of patient/parent/legal guardian _____

Date _____

To make my checkout as efficient as possible, I authorize The Vernon Dental Centre to process my balance automatically on my:

Visa/ Mastercard _____ Expiry _____

Dr. Anthony Berdan and Dr. Tyler Sheasby