vernon DENTAL CENTRE

NEW PATIENT INFORMATION

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

Sex:______________

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: ____

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_______________ CVC#____

Dr. Anthony Berdan and Dr. Tyler Sheasby