BURNABY HEIGHTS DENTAL CENTRE

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# NEW PATIENT FORM

Last Name: _____ First Name: _____ Preferred Name: _____

Birth Date (M/D/Y): _____ Sex: Male ☐ Female ☐ Other ☐

Phone #: _____ Cell #: _____ Work #: _____

Address: _____

Email: _____ Who were you referred by?: _____

Do you have dental insurance? ☐Y ☐N _____

## MEDICAL HISTORY

Are you currently being treated for a medical condition?..... ☐Y ☐N _____

Have you ever been hospitalized? ..... ☐Y ☐N _____

Have you ever had any operations? ..... ☐Y ☐N _____

Any physical symptoms we should be aware of? ..... ☐Y ☐N _____

Are you a smoker? ..... ☐Y ☐N _____

Do you have any allergies? ..... ☐Y ☐N _____

Are you pregnant or think you may be pregnant?..... ☐Y ☐N due: _____

Do you suffer from any chronic diseases or conditions? ☐Y ☐N Please circle all that apply:
Cancer, tumor, anemia, arthritis, hypertension, thyroid problems, kidney problems, diabetes, pneumonia, tuberculosis, HIV/AIDS, liver problems, seizures, epilepsy, eating disorder, cardiovascular problems, headaches, _____.

Are you taking any medications? ☐Y ☐N _____

_____

## DENTAL HISTORY

Reason for this visit _____

Last dental visit date _____ What was done then? _____

How often do you visit a dentist? _____ Previous dentist? _____

Have you had dental x-rays done before (when and where?) _____

Circle the correct amount:

I brush my teeth per day – none…once…twice…three or more

I floss my teeth per day – none…once…twice…three or more

Have you had and head/neck/jaw injuries?.....☐Y☐N

Have you had ortho/braces in the past? ☐Y ☐N

Do your gums bleed while brushing or flossing? .....☐Y ☐N

Are your teeth sensitive?.....☐Y ☐N

Do feel pain in any of your teeth? .....☐Y ☐N

Do you have any sores or lumps in your mouth? .....☐Y ☐N

Do you clench or grind your teeth? .....☐Y ☐N

Have you noticed loosening in any of your teeth?..... ☐Y ☐N

Have you ever had any gum treatment? ☐Y ☐N

Have you ever worn a bite plate or other appliance? .....☐Y ☐N

Have you had any difficult extractions in the past? .....☐Y ☐N

Do you wear dentures or partials?..... ☐Y ☐N

Have you had an unfavourable dental experience? .....☐Y ☐N

If you could change **anything** about your smile, what would you change? _____

_____

**Appointments:** A minimum charge of $50 will be made for a cancelled or no-show appointment without prior notification of 2 business days. Once an appointment is made, please remember this time has been reserved for you.

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services/ I agree to be responsible for payment of all services rendered on behalf of me or my dependants.

_____ _____

Signature of patient or guardian Date

_____ _____

Signature of dentist Date