North Langley Family Dental

Patient Information

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Title:_____ Gender: ☐ Male ☐ Female Status: ☐ Married ☐ Single ☐ Child ☐ Other
Mr/Ms/Mrs/etc.

Birth Date: _____/_____/_____ Referred by: _____ Email: _____
D M Y

Phone: _____ _____ _____ _____ Best Time to call: _____
Home Work Ext. Mobile

Address: _____

_____ _____ _____
City Province Postal Code

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Sat
☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime

Employer: _____ Phone: _____

Do you have Dental Insurance? ☐ Yes ☐ No

Primary Insurance Information:

Name of insured: _____ Date of Birth: _____ Relationship to Insured: _____

Carrier Name: _____ Group #: _____ ID #: _____

Secondary Insurance Information:

Name of insured: _____ Date of Birth: _____ Relationship to Insured: _____

Carrier Name: _____ Group #: _____ ID #: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____

Spouse or Responsible Party Information

The following is for:

☐ The patients spouse ☐ The person responsible for payment ☐ Neither / Not applicable

Name: _____ _____ _____
Last First Preferred Name

Relationship to Patient: _____

Contact Information *(if different from above)*

Phone: _____ _____ _____ _____ Best Time to call: _____
Home Work Ext. Mobile

Address: _____

_____ _____ _____
City PV Postal Code

North Langley Family Dental

Office Policies

Our philosophy is to provide you with excellent care. In meeting this high standard, however, some procedures may not be covered by your dental plan. We do not choose treatment based on your coverage but rather, your individual dental needs and desires.

CANCELLATION POLICY:

Two business days notice is required to change your appointment or a FEE will be charged according to the amount of time booked for your reserved appointment. Failure to attend appointments or provide adequate notice deprives other patients of access to treatment, some of which may be urgent in nature. This adds significantly to the cost of everyone's dental care.

DENTAL INSURANCE POLICY:

Our office accepts insurance assignments for most dental plans on behalf of our patients. Due to extensive cutbacks by all dental plans. we feel it is necessary to inform you that some procedures may not be covered by your plan. Dental plans vary greatly. The forms. conditions. and percentages of payments are contracted between you, your employer. and the insurance company. The percentage of coverage relate to Insurance Company fee schedules, which may not necessarily correspond to Sage Dental Centre's fee schedule and/or the current College of Dental Surgeons of BC fee schedule. Please take the time to read over your individual plan and be aware of its limitations and changes (e.g scaling limits, recall limits). This is YOUR responsibility. All services not covered by your plan will be billed to you.

CLAIMS POLICY

I authorize the release, to my dental insurance plan administrator and the Canadian Dental Association, information contained in claims submitted electronically.

I hereby assign my benefits, payable from claims submitted electronically, to Sage Dental Centre and authorize payment directly to said company.

This authorization shall continue in effect until the undersigned revokes the same. I will allow sharing my demographic, medical and dental information with other health providers if necessary.

☐ **I have read and understand the above policies and agree to their content.**

_____ _____

Signature of Patient, Parent, or Guardian (The subscriber) **Date**

DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Sage Dental Implant and Smile Centre, to use photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

I consent to allow the photographs to be used for the following:

- **Dental Records**
- **Dental Research**
- **Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books Marketing material, including websites and printed materials, patient education**

I further understand that if the photographs and/or vides are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ **Check here if you do not want your full face shot used for any of the above purposes**

_____ _____

Patient Signature: **Date**

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	**YES**	**NO**
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]		
2. Have you had an unfavorable dental experience?		
3. Have you ever had complications from past dental treatment?		
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?		
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?		
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?		
GUM AND BONE	**YES**	**NO**
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?		
8. Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth?		
9. Have you ever noticed an unpleasant taste or odor in your mouth?		
10. Is there anyone with a history of periodontal disease in your family?		
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?		
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?		
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?		
TOOTH STRUCTURE	**YES**	**NO**
14. Have you had any cavities within the past 3 years?		
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?		
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?		
18. Do you have grooves or notches on your teeth near the gum line?		
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		
20. Do you frequently get food caught between any teeth?		
BITE AND JAW JOINT	**YES**	**NO**
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)		
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?		
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?		
25. Are your teeth becoming more crooked, crowded, or overlapped?		
26. Are your teeth developing spaces or becoming more loose?		
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?		
28. Do you place your tongue between your teeth or close your teeth against your tongue?		
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		
30. Do you clench or grind your teeth together in the daytime or make them sore?		
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?		
32. Do you wear or have you ever worn a bite appliance?		
SMILE CHARACTERISTICS	**YES**	**NO**
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?		
34. Have you ever bleached (whitened) your teeth?		
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?		
36. Have you been disappointed with the appearance of previous dental work?		

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury _____
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine _____
   - penicillin _____
   - erythromycin _____
   - tetracycline _____
   - sulfa _____
   - local anesthetic _____
   - fluoride _____
   - chlorhexidine (CHX) _____
   - Iodine _____
   - metals (nickel, gold, silver, _____)
   - latex _____
   - nuts _____
   - fruit _____
   - milk _____
   - red dye _____
   - other _____
3. heart problems, or cardiac stent within the last six months _____
4. history of infective endocarditis _____
5. artificial heart valve, repaired heart defect (PFO) _____
6. pacemaker or implantable defibrillator _____
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) _____
8. heart murmur, rheumatic or scarlet fever _____
9. high or low blood pressure _____
10. a stroke (taking blood thinners) _____
11. anemia or other blood disorder _____
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____
14. chronic ear infections, tuberculosis, measles, chicken pox _____
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____
17. kidney disease _____
18. liver disease or jaundice _____
19. vertigo (e.g. "the room is spinning") _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) _____
22. high cholesterol or taking statin drugs _____
23. diabetes (HbA1c = _____) _____
24. stomach or duodenal ulcer _____
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____
27. arthritis or gout _____
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____
29. glaucoma _____
30. contact lenses _____
31. head or neck injuries _____
32. epilepsy, convulsions (seizures) _____
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____
34. viral infections and cold sores _____
35. any lumps or swelling in the mouth _____
36. hives, skin rash, hay fever _____
37. STI/STD/HPV _____
38. hepatitis (type ____) _____
39. HIV/AIDS _____
40. tumor, abnormal growth _____
41. radiation therapy _____
42. chemotherapy, immunosuppressive medication _____
43. emotional difficulties _____
44. psychiatric treatment or antidepressant medication _____
45. concentration problems or ADD/ADHD _____
46. alcohol/recreational drug use _____

ARE YOU:

47. presently being treated for any other illness _____
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____
49. taking medication for weight management _____
50. taking dietary supplements, vitamins, and/or probiotics _____
51. often exhausted or fatigued _____
52. experiencing frequent headaches or chronic pain _____
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____
54. considered a touchy/sensitive person _____
55. often unhappy or depressed _____
56. taking birth control pills _____
57. currently pregnant _____
58. diagnosed with a prostate disorder _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**