SALMONARM Dental

Dr. Russell Kearl

Dr. Luke Hawkins

PATIENT INFORMATION

Legal Name: _____ Male _____ Female _____

Preferred Name: _____ Date of Birth (D/M/Y): _____

Phone: _____ Cell: _____ Work: _____Ext:_____

Mailing Address: _____ City:_____Prov:_____Postal Code_____

Street Address: _____ City:_____Prov:_____Postal Code_____

Email: _____ Occupation: _____

Emergency Contact: _____Relation: _____Phone: _____

How did you hear about us? _____

OFFICE POLICIES

Insurance companies will only pay a portion of your treatment. While some claim to cover 100% of treatment costs, they often only cover 100% of the fee that they set for that treatment, not the fee that is set by the British Columbia Dental Association. This means that there is almost always a portion that will be charged to the patient. Payment for service is expected at the end of each appt. As a courtesy to our patients, our staff may handle insurance forms but it is your responsibility to be aware of any limits to your insurance plan, as the insurance company is bound by the Personal Health Information Act and will not share that information with the Dental Office. It is your responsibility to pay the balance that they do not cover.

Estimated fees given are only good for six months, and are subject to change.

Cancelation of appointments with less than 48hrs notice may be subject to a $50.00 Late Cancelation Fee

All dental treatment requires a diagnostic exam. This exam will require x-rays. We reserve the right to refuse to provide treatment if you do not have the proper diagnostic tests. This includes dental cleanings. Guidelines from the CDHBC prevent our Hygienists from treating you if you have not had an exam with the dentist in the last 365 days.

We do our best to maintain your privacy. Information collected on this form and throughout your treatment will be confidential; however, it may be used for the following: Communication with you, your insurance company, and other health care providers; if required by our governing bodies (BCDA, CDA, CDSBC), the RCMP, or another party as permitted or required by law. Parents not listed on file requesting information for their children will be required to show proof of custody.

All medical treatments carry with them a certain amount of risk. These risks are greatly minimized when you make your Dentist aware of existing concerns. Not informing your Dentist of medications, allergies, existing or past medical conditions, or recreational drug use, may lead to severe conditions or death. Please do your best to make sure that your medical information is accurate and up to date.

One risk of dental treatment, although rare, is paresthesia. This is where a nerve that has been frozen or otherwise traumatized may temporarily or permanently lose feeling in the tongue and /or face.

I have read and understand the above information:

- *Signature of Patient/Guardian:* _____ *Date:* _____

OVER -->>>>>>>

Medical History

Do you or have you ever had any of the following:

- AIDS/HIV
- Arthritis
- Anxiety
- Asthma
- Autoimmune Disease
- Artificial Joint Replacement
- Artificial Heart Valve
- Back/Neck Pain
- Blood Disorder
- Breathing/Lung problems
- Cancer
- Chemotherapy
- Radiation Treatment
- Congenital Heart Disorder
- Cardiac Stent
- Diabetes (Type 1 or 2)
- Depression
- Epilepsy/Seizures
- Excessive Bleeding
- Fainting/Dizziness
- Gastrointestinal Issues
- Glaucoma/Eye Disorders
- Head Injury
- Heart Disease(explain)
- Heart Murmur
- Hepatitis (A/B/C)
- High/Low Blood Pressure
- Headaches/Migraine
- Heart Attack (date?)
- Hormone Deficiency
- Infective Endocarditis
- Kidney Disease
- Liver Disease
- Mental Disorders
- Osteoporosis
- Currently Pregnant (Due date?)
- Pacemaker
- Rheumatic/or Scarlet Fever
- Sinus Issues
- Stroke (date?)
- Sleep Apnea/Snoring
- Tuberculosis
- Tumors/Growths
- Thyroid Disease
- Ulcers
- Venereal Disease
- Vertigo

1. Name of General Physician? Phone Number? _____
2. **Medications:**_____
   _____
3. **Allergies:** Latex / Codeine / Penicillin / Clindamycin / Sulfa Drugs / NSAIDS (Aspirin, Ibuprofen, Naproxen etc.) Other Allergies? _____
4. Have you ever been recommended to take Antibiotics prior to dental treatment or surgery? _____
5. Explain your tobacco use history? _____
6. Do you drink Alcohol? YES / NO, Frequency: _____
7. Do you use Recreational Drugs? YES / NO. **Some drug interactions and dental local anesthetic may be <u>LETHAL</u>**.
   If yes, what kind and how recently?_____
8. Is there any other general health condition, disease or illness not listed above? Please explain.
   _____
   _____

This medical information is accurate to the best of my knowledge and I will inform the dental professional if there are any changes

- *Signature of Patient/Guardian:* _____ *Date:* _____

Dental History (New Patients Only)

Date of last dental visit? Reason? _____

Previous Dentist? What city _____

Are you concerned with the appearance of your teeth? YES / NO, Explain _____

Are you having any pain in your teeth? YES / NO, Explain: _____

Have past dental experiences been satisfactory? YES / NO, Explain: _____

Do you have any of the following?

- Sensitivity to: Hot / Cold / Biting / Sweets
- Bleeding gums
- Broken teeth or fillings
- Chronic bad breath
- Suffering from dry mouth
- Food catches between teeth
- Grinding or clenching
- Had an injury to teeth or jaw
- Loose teeth
- Cold sores
- Treated for gum disease or told you have bone loss or gum loss around your teeth
- Jaw pain
- Sores/Growths or Swellings in mouth
- Dental fear/Anxiety
- Reaction to dental Anesthetic
- Had Ortho.Treatment