SALMONARM Dental

Dr. Russell Kearl
Dr. Andrew Irwin

PATIENT INFORMATION

Legal Name:_____ ❑Male ❑Female
Last First Middle

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

Phone:_____Cell: _____ Work: _____ Ext:_____

Address: _____City_____Prov_____**Postal Code**_____

E-mail:_____ Occupation:_____

Emerg Contact:_____Relation:_____Phone:_____

How did you hear about us? ❑Google ❑Sign ❑Facebook ❑Website ❑Yellow Pages ❑Radio ❑Newspaper ❑Kong

❑Friend (Who do we thank?)_____❑Other_____

Office Policies

Insurance companies will only pay a portion of your treatment. While some claim to cover 100% of treatment costs, they often will 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 services is expected at the end of each appointment. As a courtesy the 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 info with the Dental Office. It is your responsibility to pay the balance that they do not cover.

Estimated fees given are only good for a 6 month period, and fees may be subject to change.

Cancelation of appointments with less than 48hrs notice may be subject to a $50 Cancelation fee.

All dental treatment requires a thorough diagnosis/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 CDHBC prevent our Hygienists from treating you if I have not had an exam with the dentist in the last 365 days.

We do our best to maintain your privacy. Information collected on the form and throughout your treatment will be confidential. It may be used in order for the Following: Communication with you, your insurance company, and other healthcare providers; Your diagnosis and treatment; 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 always 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 loose feeling in the tongue and/or face.

I have read and understand the above information:

_____ _____ _____
Print Name Date Signature

Continued on other side…

HEALTH INFORMATION

Date of Last Dental Visit_____Reason:_____

Previous Dentist:_____City:_____

Name of General Physician:_____Phone:_____

Are you concerned with the appearance of your teeth. ❑Yes ❑No

If Yes, Explain_____

Are you having any pain in your teeth? ❑Yes ❑No

If Yes, Explain_____

_____

Do you: ❑ Play Sports ❑ Grind your teeth ❑ Snore ❑ Have High Blood Pressure

Do you have, or have you ever had:

❑ Blood or Heart Disease or Abnormality (Anemia, Excess Bleeding, Murmer, Artificial Valve, Pacemaker, Blood Pressure, etc.):_____

❑ Head, Neck or Brain Injury or Other (Seizures, Stroke, Mental Disability, Sinus, Eyes, etc.):

_____

❑ Internal Organ Issues: (Kidney, Ulcers, Liver, Diabetes, etc.):_____

❑Cancer, Benign Tumors or Growths:_____

❑ Radiation Treatments:_____

❑ Bone or Joint Issues (Osteoporosis, Arthritis, Prosthetic Joint etc.):_____

❑ Other: (Rheumatic Fever, Pregnancy, etc.):_____

Have you ever had any complications from Dental Treatment? ❑Yes ❑No

If Yes, Explain_____

Do you have any health problems that need further clarification or testing? ❑Yes ❑No

If Yes, Explain_____

Have you ever used Tobacco? ❑Yes ❑No If Yes: Type:_____ Frequency:_____

❑Quit? When?_____ Type:_____ Past Freq:_____

Do you Drink Alcohol? ❑Yes ❑No Frequency?_____

Do you use recreational Drugs? ❑Yes ❑No **Some drug interactions may be <u>LETHAL.</u>** If yes, what and how recently_____

Allergies: ❑Latex ❑Codeine ❑Penicillin ❑Clindamycin

❑Other Allergies:_____

Current Medications:_____

_____

Further information on any of the above:_____

_____

_____

_____

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

Signature of Patient/Guardian Date