WELCOME TO OUR PRACTICE

We are thrilled that you have chosen us to help you maintain your teeth for a lifetime and we will do our best to treat you like a member of our family. Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. Please answer the questions as accurately as you can. If you have any questions or doubts, please ask the receptionist or the dentist, who is available to assist you with the completion of this form. All information is **strictly confidential** and will remain in this office.

Name ______________________________________Prefers: ____________ Occupation:_______________________

Street/Apt # __________________________________ City/Town _________________________ Province _______

Postal Code _______________ Date of Birth____________________ Provincial Health Card # _____________________________

Phone (H) _______________ Phone (W) _________________ Phone (Cell) _______________

Email: ____ Emergency Contact ___________________ Phone _______________

Employer: _____________________

Are other family members patients at our office?_________________________

How did you hear about us? ________________________________

How can we make your dental experience exceptional? ____

What is your main reason for coming to see us today?____

Financial Information:

Account Guarantor: ____

Do you have insurance? Y N

PRIMARY DENTAL INSURANCE: *Patient's relationship to insured:* □ *Self* □ *Spouse* □ *Child Other*
Name of Insurance: ____
Group Policy #: ___________________________________ Division: ____________________________
ID/Certificate #: ____
Name of Insured (PRINT): ______________________________ ______________________________
Date of Birth (d/m/y): ____
Insured's Employer: ____
Telephone: ____

Maximum annual coverage:$_________ Coverage for: Basic____% Major Rest.____% Other___%

SECONDARY DENTAL INSURANCE: *Patient's relationship to Insured:* □ *Self* □ *Spouse* □ *Child*□ *Other*
Name of Insurance: ____
Group Policy #: ______________ Division: ____
ID/Certificate #: ____
Name of Insured: ____
Date of Birth (d/m/y): ____
Insured's Employer: ____
Telephone: ____

OFFICE INFORMATION FOR OUR GUESTS

- We will be happy to submit your insurance claim as a courtesy and you will be reimbursed directly by your insurance company. All treatment must be paid for at time of service. For your convenience we accept Master Card, VISA, Debit or cash. For fees over $2000.00, we require cheques due to exorbitant merchant fees billed to us as a percentage of the visa/master card charge.
- I have reviewed a copy of the Practice's privacy policy, which describes the kinds of personal health information that the Practice collects and how it uses and discloses personal health information
- I understand insurance is not a guarantee of payment**; frequently** you will ***not*** be reimbursed for the full amount paid at our office.
- It is the patient's responsibility to know the coverage and limitations of his/her Dental Insurance Policy even though we will assist with helping you understand your benefits.
- Upon your request, we can only give an ***estimate*** of what your insurance company may pay (**it is not a quote**).
- Major work (crowns, bridges, root canals, implants) will require a 50% deposit before any treatment is started. This will reserve your appointment time.
- Please remember we do require 2 business days notice for appointment changes or late fees will be charged.
- If there are any changes in your medical condition, please notify our dental office immediately.
- VIP Service. For your convenience, treatment can be charged directly to your credit card:

  # ____ Expiry _______

  Card Type: ____________________________Security Code (last 3 digits on back of card _____________

• Interest will be charged on all overdue accounts at a rate of 18% per year.

I have read and understand the above information.

Guests Signature: _________________________________Today's Date: _________________________

CONSENT FOR PHOTO'S:

I herby give my consent to use my dental photos as Dr. Sutherland/Shaffner see fit:

- *for the advancement of both restorative and cosmetic dentistry education*
- *for viewing by other dental professionals and within study clubs*
- *for patient education & promotional literate*

I release and forever discharge Dr. Sutherland/Shaffner and his practice from any claim, demands or liabilities on the account of such use.

Authorized Signature: ________________________________ *Date:*_______________________________________

This form is strictly confidential. ***Please circle below according to YES or NO. Please list medicines (below "Comments/Meds") and WHAT THEY ARE FOR in brackets.***

Physician ___________________________ Address ___________________________________ **Comments/Meds:**

Are you currently under the care of a physician for a medical problem? Yes No

For what condition(s)?____

WOMEN ONLY: Are you, or do you suspect you might be pregnant?________ Yes No

WOMEN ONLY: Are you taking Birth Control Pills? ____________________ Yes No

Are you taking any medications (please list on right)?_________________________ Yes No

Are you allergic to any medications?_______________________________________ Yes No

Do you have any other allergies?____ Yes No

Have you had problems with penicillin, codeine, antibiotics,

dental freezing (local anaesthetic) or other medications?______________________ Yes No

Is there any reason you cannot take ibuprofen (also called Advil/Motrin)?_______ Yes No

Do you have stomach issues such as gastric reflux/ulcers? _________________________Yes No

Have you ever had rheumatic fever or infective endocarditis? (Any heart damage?) Yes No

Do you have any artificial joints or other prosthesis?_________________________ Yes No

Do you have an artificial heart valve/implant?_____________________________ Yes No

Do you require antibiotics before a hygiene visit/dental treatment? _____________ Yes No

Do you suffer from any form of cardiovascular disease?______________________ Yes No

Do you have seizures/epilepsy, asthma, diabetes, hepatitis, kidney disease or glaucoma? Yes No

Have you had any organ transplants, such as kidneys? ______________________ Yes No

Do you have any family history of diabetes? _______________________________ Yes No

I am a smoker (please list how many packs/day) ___________________________ Yes No

Do you bruise easily or bleed more than other people you know when cut?______ Yes No

Have you had any difficulties associated with previous dental treatment?_______ Yes No

Have you ever tested HIV positive?____ Yes No

Have you ever had cancer surgery/radiation for a tumour in your head/neck_____ Yes No

Do you experience excessive snoring/daytime drowsiness, or have trouble

sleeping at night due to snoring? _______________________________________ Yes No

Is there anything else we should know about your health not covered here?______ Yes No

Do you have a latex allergy? ____ Yes No

GENERAL RELEASE

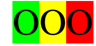
I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to my questions regarding my medical/dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that it is my responsibility for payment of the dental services for myself and dependants, and I assume responsibility for fees associated with these services whether or not they are covered by my dental insurance.

Signature of Patient/Guardian __________________________________ Date ________________________

Reviewed by Dentist____

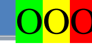
DENTAL HISTORY

Adapted from Kois Center, LLC

LOW Acceptable   Moderate May require further attention   HIGH Requires immediate attention 

How would you rate the condition of your mouth? ❑Excellent ❑Good ❑Fair ❑Poor
Previous Dentist ___________________________ How long were you a patient? ______________
Date of last dental check up? ______________ Date of most recent xrays? ______________
I routinely see my dentist every: ❑3 months ❑4 months ❑6 months ❑12 months ❑Not routinely

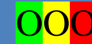
PLEASE ANSWER *YES* OR *NO* TO THE FOLLOWING: YES NO

PERSONAL HISTORY 

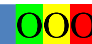
Question	YES	NO
• Are you fearful of dental treatment? Scale of 1 to 10 (very) _1_ 2 _3 _4 _5 _6 _7 _8 _9 _10___________	❑	❑
• Have you had an unfavourable dental experience? ____	❑	❑
• Have you ever had complications from past dental treatment? ________________________________	❑	❑
• Have you ever had trouble getting numb or reactions to dental anaesthetic? ___________________	❑	❑
• Did you ever have braces, orthodontic treatment or had your bite adjusted? ___________________	❑	❑
• Have you had any teeth removed? ____	❑	❑

SMILE CHARACTERISTICS

Question	YES	NO
• Is there anything about the appearance of your teeth that you would like to change? _____________	❑	❑
• Have you ever whitened (bleached) your teeth? _____________________________________	❑	❑
• Are you self conscious about your teeth? ____	❑	❑
• Have you been disappointed with the appearance of previous dental work? ___________________	❑	❑

BITE AND JAW JOINT 

Question	YES	NO
• Do you/would you have any problems chewing gum? _________________________________	❑	❑
• Do you/would you have any problems chewing bagels or other hard foods? __________________	❑	❑
• Have your teeth changed in the last 5 years, become shorter, thinner, or worn? ________________	❑	❑
• Do you have any problems with sleep or wake up with an awareness of your teeth? _____________	❑	❑
• Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping) _______	❑	❑
• Do you have tension headaches or sore teeth? _____________________________________	❑	❑
• Do you wear or have you worn a bite appliance? ____________________________________	❑	❑

TOOTH STRUCTURE 

Question	YES	NO
• Have you had any cavities within the past 3 years? __________________________________	❑	❑
• Do you have a dry mouth? ____	❑	❑
• Are any teeth sensitive to hot, cold, biting, or sweets? _______________________________	❑	❑
• Have you ever had a toothache, cracked filling, broken, chipped, or cracked tooth? _____________	❑	❑
• Do you avoid brushing any part of your mouth? ____________________________________	❑	❑
• Do you feel or notice any holes (i.e. pitting) in your teeth? _____________________________	❑	❑

GUM AND BONE

Question	YES	NO
• Have you ever been diagnosed or treated for periodontal (gum) disease? ____________________	❑	❑
• Have you ever experienced gum recession? _______________________________________	❑	❑
• Is there anyone with a history of periodontal disease in your family? ______________________	❑	❑
• Do your gums bleed when brushing, flossing or eating? _________________________________	❑	❑
• Are your teeth becoming loose? ____	❑	❑
• Have you ever noticed an unpleasant taste or odour in your mouth? ________________________	❑	❑
• Have you experienced a burning sensation in your mouth? _____________________________	❑	❑

Patient's Signature ______________________________________ Date ______________________

Doctor's Signature ______________________________________ Date ______________________