Coast DENTAL CENTRE

Medical History

Patient Name: _____ **Guardian Name** (if minor): _____
Date of Birth M:_____ D: _____Y:_____ Address: _____City: _____
Province: _____ Postal code _____ Home #: _____ Cell #: _____
Work #: _____ (optional) Email: _____
Employer & Occupation: _____
Family Doctor: _____ Office phone #:_____
Name of emergency contact: _____Phone #: _____
Is English your first language? ☐ **Yes** ☐ **No** If **no,** do you need an interpreter? ☐ **Yes** ☐ **No**
Do you have any cultural or religious beliefs that might limit the delivery of oral health care treatments? ☐**Yes** ☐**No**
If **yes,** please explain: _____
What is your estimate general health? ☐ **Excellen**t ☐ **Good** ☐ **Fair** ☐ **Poor**

2 QUESTIONS

1. There are 5 reasons why a person resists going to the dentist; are any of these a factor & if so choose the **ONE** that is most important. ☐ **Fear** ☐ **Time** ☐ **Finances** ☐ **Trust** ☐ **No sense of urgency** ☐ **N/A**
2. Although all of these are important to your oral health which **ONE** of these are most important to you:
   ☐ **Cosmetic** ☐ **Function** ☐ **Comfort** ☐ **Longevity**

DO YOU HAVE or HAVE YOU EVER HAD

1. Hospitalization for illness or injury: ☐ **Yes** ☐ **No** If **yes,** please provide details: _____
2. An allergic reaction to: ☐ aspirin ☐ ibuprofen ☐ acetaminophen ☐ codeine ☐ penicillin ☐ tetracycline ☐ local anesthetic ☐ metals (nickel, gold, silver) ☐ fluoride ☐ sulfa ☐ erythromycin ☐ latex ☐ other_____
3. Joint Replacement: ☐ **Yes** ☐ **No** If **yes** what joint? _____ When? _____
4.

Description	YES	NO	Description	YES	NO
Artificial Heart Valves			**A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention within the last six months**		
Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits			**Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device**		
A history of infective endocarditis			**A cardiac transplant that developed a problem in a heart valve**		
Heart Attack - Date:			Emotional Disorders, Depression, Psychiatric Txt		
Cardiac Stent(s) - Date:			Epilepsy, convulsion (seizures)		
Stroke - Date:			Muscular dystrophy, multiple sclerosis		
High or Low Blood Pressure			Neurologic problems (ADD)		
Anemia or other blood disorder			Hepatitis - Type:		
Prolonged bleeding due to slight cut			Breathing or Sleep Problems (i.e. snoring, sinus)		
On blood thinners i.e. Coumadin, Adult Aspirin, Plavix (INR #: _____)			Unexplained sore throat, feeling like something is caught in throat or chronic hoarseness		
Emphysema			HIV/AIDS		
Tuberculosis			Colitis/Crohns		
Asthma: Where do you keep your inhaler?			Eating Disorder (Bulimia, Anorexia Nervosa)		
Thyroid Disease			Lupus		
Kidney Disease			Cold Sores		
Liver Disease			Head or Neck injuries		
Jaundice			Lumps or swelling in the mouth or neck area		
Cancer - Type:			Digestive disorders (i.e. Gastric reflux)		
Radiation/Chemotherapy			Drug Dependency - Type:		
Male Only: Prostate disorders			Consumer of alcohol - # times per week:		

5. Female: ☐ Osteoporosis? If **No,** have you ever been tested for osteoporosis? ☐ Yes ☐ No ☐ Take Fosamax, Fosamax plus D for osteoporosis or for any other reason? ☐ Prone to yeast infections

6. Any medical condition(s) or impending surgery not listed ☐ **Yes** ☐ **No.** If **yes**, please indicate:
_____

List all prescribed **MEDICATIONS** & over-the-counter **SUPPLEMENTS** & **VITAMINS** that you are currently taking.

Drug	**Purpose**	**Drug**	**Purpose**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Prevalence & severity of gum conditions increases with the following risk factors. In fact, 90% of all systemic diseases have an oral manifestation & gum disease can affect major organs. Eliminating gum disease is especially important to the oral & overall health of the following patients (please indicate which apply):

TOBACCO USE

- Current Tobacco User: ☐ Yes ☐ No If yes, do you want to quit? ☐ Yes ☐ Contemplation Phase ☐ No
  What form (cigarettes, pipe, chew, marijuana, e-cigarettes etc.)? _____
  How much/day _____ For How Long? _____
- Previous Tobacco user: ☐ Yes ☐ No If yes, when did you quit**?** _____

OTHER SYSTEMIC DISEASES

- Diabetes: ☐ Yes ☐ No What type? ☐ Type I ☐ Type II. Date of last HbA1c: _____.
  How is your diabetes control? ☐ Good (<7% A1c/140 mg/dL) ☐ Fair (7-9% A1c/140-220 mg/dL) ☐ Poor (>9 A1c/>330mg/dL) ☐ Don't Know
- Rheumatoid Arthritis: ☐ Yes ☐ No
- Cardiovascular Disease ☐ Yes ☐ No If yes, please specify _____

GENETICS

- Family History of Gum Disease: ☐ Yes ☐ No ☐ Don't know. If yes, who _____.
- Family History of Diabetes: ☐ Yes ☐ No If yes, who? _____
- Family History of Alzheimer's disease: ☐ Yes ☐ No ☐ Don't know.

STRESS

Is your stress level high? ☐ Yes ☐ No Are you currently going through any life altering events? ☐ Yes ☐ No
If yes, what? (optional) _____

OVERWEIGHT

Are you overweight? ☐ Yes ☐ No List height: _____ List weight: _____

MEDICATIONS

Some drugs can affect your oral health. Are you taking any of the following: ☐ Dilantin ☐ Ca+ Channel Blockers ☐ Immunosuppressant's for organ transplantation ☐ Oral contraceptives ☐ Anti-depressants

HORMONES

Do any of the following apply? ☐ Puberty ☐ Pregnant ☐ Menopause ☐ Post-Menopause ☐ Nursing

CLENCHING & GRINDING

Do you clench or grind? ☐ Yes ☐ No

***** Changes to medical/dental history particularly, related to medications, allergies, recent hospitable visits, and glucose and INR numbers must be updated with your dental professional.***

***** It is contraindicated to treat patients who have not taken their required premedication.***

Coast DENTAL CENTRE

Dental History

I would rate the condition of my mouth as? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
What is your current home care regime?
Floss ☐ Yes ☐ No If yes, how often?_____

Waterpik ☐ Yes ☐ No If yes, how often? _____
Mouth rinse ☐ Yes ☐ No If yes, ☐ with alcohol ☐ without alcohol ☐ with fluoride ☐ without fluoride
Tooth Brush ☐ Manual ☐ Electric How often?_____

Other home care products: _____

Do you have any immediate concerns?_____

Cosmetics	**YES**	**NO**
Is there anything about the appearance of your teeth that you would like to change?		
Have you ever whitened (bleached) your teeth? If no, would you like to? ☐ Yes ☐ No		
Are you interested in Veneers, Crowns, Invisalign (clear braces), Braces, White fillings?		
Notes:		

Function		
Do you have problems chewing gum and/or hard foods?		
Are your teeth crowding or developing spaces?		
Are there areas in your mouth where food gets trapped?		
Do you have problems with your jaw joint/TMJ? (pain, sounds, limited opening, locking, popping)		
Do you wear or have worn a night appliance/ guard or sports guard?		
Notes:		

Comfort		
Do you have any toothaches currently?		
Do you avoid brushing any part of your mouth?		
Do you experience discomfort with your soft tissues? ie. Lips, cheeks, tongue		
Are any of your teeth sensitive to hot, cold, sweets or pressure?		
Notes:		

Longevity		
Do your gums bleed when brushing, flossing or eating?		
Have you ever noticed an unpleasant taste or odour in your mouth?		
Do your gums and or teeth hurt during cleanings?		
Have you ever had your teeth cleaned with freezing?		
Notes:		

I, _____ (patient/ guardian name), certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information.

Patient/ parent/ guardian Signature: _____ Date: _____

Insurance Policy

Coast Dental Centre is dedicated in providing best recommended services for the maintenance and/or improvement of our patients' oral health. Treatment recommendations are based on individual oral health care needs and not in accordance to your dental plan coverage.

What patients need to know

- Insurance dental plans are not customized to your individual dental health needs and may or may not cover all your treatments required.
- It is always a good idea to learn what your plan generally covers including eligible services, percentage coverage and annual dollar maximums. Ask your plan purchaser/plan provider for details or refer to your dental insurance guide.
- We will collect the full amount of treatment rendered at the end of each appointment. **We will submit dental claims on your behalf** and your insurance will reimburse the plan member for the amount covered based on your plan. Please call your insurance provider if you wish to set up a direct deposit.
- Major dental procedures typically include lab fees. Costs are determined by an outside lab and may or may not be covered by your plan. Any costs not covered by your dental plan are considered as your out-of-pocket expense.
- Insurance companies do not inform the office when changes in policies, carriers, and termination of plans occur.

Verify your coverage before treatment appointment

- To learn what your plan(s) will cover before your treatment, simply ask our front staff. We are happy to submit a predetermination of benefits to your dental insurance provider(s). This is an estimate of the proposed treatment submitted to your dental plan provider(s) to determine what your plan will cover. In some cases, insurance carriers only correspond with their members. If you need our assistance in understanding insurance assessments, please do not hesitate to call.
- As a new patient, we will contact your insurance carrier(s) to obtain the general breakdown details of your plan. Doing this will assist clinicians in providing you a thorough treatment plan. Please note that if your plan changes or terminates, you must advise our office as soon as possible, as previously obtained information may no longer be accurate.

_____ (initials) I have read and agree to the insurance policies as outlined above.

Insurance details

PRIMARY INSURANCE
Plan member's name: _____ Insurance company: _____
Policy/plan/group number:_____ Certificate ID: _____
If the plan member is not a patient of our office please provide:
Name of plan member & relationship to plan member: _____relationship: _____
Date of birth of the plan member: M:_____ D: _____Y:_____

SECONDARY INSURANCE
Plan member's name: _____ Insurance company: _____
Policy/plan/group number:_____ Certificate ID: _____
If the plan member is not a patient of our office please provide:
Name of plan member & relationship to plan member: _____relationship: _____
Date of birth of the plan member: M:_____ D: _____Y:_____

Cancellation Policy

Our dental office requires **2 business days cancellation notice** in which case no charge will be made. This policy is to ensure that our staff is provided with enough time to allocate the appointment to another patient in urgent need of treatment. If patient does not show up or does not provide a 2 business days cancellation notice, a fee will be charged on the account of $90.00.

_____ (initials) I have read and agree to the policies as outlined above.

Privacy Statement For Patients

Privacy of our patient's personal information is important to us. We are committed to collecting, using, and disclosing personal information responsibly.

PERSONAL INFORMATION

Personal information for our purposes is; that information necessary for the provision of professional oral health care services provided to you, and information necessary to administer this dental practice. Personal information includes all that information provided by you to us on our patient information/health/medical history form at the first visit and any subsequent visits. Personal information may also include any information provided by you to us during the normal course of communication between patient and dental office staff. We will use and disclose only information provided to us by you or another person acting on your behalf.

INFORMATION PROTECTION

We are committed to protecting your personal information. We have established and implemented a variety of security measures to properly manage and safeguard your personal information from loss, theft and unauthorized access. Access to your personal information shall be on a "need to know" basis.

INFORMATION DISCLOSURE

Your personal information will only be disclosed to those who are on a need-to-know basis, and the disclosed information will be limited to only the information that is necessary for the recipient such as sharing recent x-rays, insurance plan information, patient information such as name, phone number and date of birth. Providers who are considered to be on a need-to-know basis include other dentists, health care providers (i.e. dental specialists, personal physicians), dental benefit providers, and consultants for educational purposes in ensuring "best practices" are being administered. Our office uses Recall Systems Pro – an automated e-mail and text appointment reminder system. With your consent, Recall Systems Pro has access to your e-mail address and/or mobile number provided in order to send automated appointment reminder messages.

INFORMATION RETENTION AND DESTRUCTION

We will retain your personal information for the period necessary to continue providing oral health services to you, and for its related administration. We will destroy information in a secure manner when the information is no longer necessary for the provision of oral health services and is not required to be retained for compliance with provincial or federal regulations or statutes.

YOUR ACCESS TO YOUR RECORDS

We are committed to providing you with open access to your personal information held by us. You may at any time ask us to see your records held by us and to request amendments to that information. We will provide

access to you within a reasonable timeframe recognizing your desire for the information and our need to carry on our practice with limited interruption.

COMPLAINT PROCESS
Should you wish to make a formal complaint regarding our privacy practices, please do so in writing to our privacy officer by e-mail to info@coastdental.ca.

Privacy Consent

_____ I give permission to Coast Dental Center to discuss any medical and dental information/treatment with another individual other than myself as listed below:

_____	_____	_____
Name of spouse/parent/legal guardian	Relationship to you	Phone No. (if named individual is not our patient)
_____	_____	_____
Name of spouse/parent/legal guardian	Relationship to you	Phone No. (if named individual is not our patient)

_____ (initials) I give permission to Coast Dental Centre to contact my insurance provider to receive breakdown details, send pre-determination of benefits for recommended treatment, and to follow-up with claims assigned to the office. I understand that when contacting insurance providers, the insurance company may ask to confirm the identity of the plan holder by confirming name, address, and date of birth.

_____ (initials) I consent to have my dental records, including periodontal charting and x-rays, insurance information and personal information shared if treatment is being referred to another dental care provider.

_____ (initials) I agree to receive electronic communication from Coast Dental Center including appointment reminders, updates and text messages. I am aware that I can opt-out of the e-mail and text reminders at any time.

_____ (initials) I am aware that a comprehensive copy of the Coast Dental Center Privacy Policy can be found at www.coastdental.ca.

_____ (initials) I have read and agreed to all policies outlined above.

Patient/ parent/ guardian Signature: _____ Date: _____