Coast DENTAL CENTRE

MEDICAL HISTORY

Patient Name: _____ Guardian Name (if minor): _____

Date of Birth (DD/MM/YY): ____ / _____/ _____ Address: _____Postal Code _____

Home #: _____ Cell #:_____ Work #: _____(optional)

Email: _____Best way to contact you: □Cell □Home □Phone □Text □Email

Employer & Occupation: _____

Family Doctor: _____ Phone #:_____

In the event of an emergency, whom should we contact? _____ Phone #: _____

How did you hear about our office? □Walk-by □Website □Yelp □Google Search □Facebook □Friend
Who should we thank for referring you: _____
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 and if so, choose **ONE** that is most important. □Fear (how fearful 1-10 (most)) ____ □Time □Finances □Trust □No sense of urgency □N/A
2. Although all of these are important to your oral health, which **ONE** is the 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. **YES NO** **YES NO**

Artificial Heart Valves			**A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention with in 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:		

Coast DENTAL CENTRE

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 and vitamins that you are currently taking.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Gum disease has been linked with an increased risk for many chronic diseases. 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? _____

Tobacco users are more likely to develop gum disease which is more severe and more difficult to eradicate. Gum disease itself has recently been linked with an increased risk for heart disease. Since tobacco users are already at an increased risk for heart disease (and since gum disease only worsens that risk) it is vitally important for tobacco users to do whatever is necessary to eliminate gum disease.

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 (>9A1c/>330mg/dL) □ Don' Know

Diabetes is a well-known risk factor for gum disease. Research is confirming that untreated gum disease makes it harder for you to control your blood sugar. Elimination of gum disease can improve your blood sugar control reducing your risk for the serious complications of diabetes.

Rheumatoid Arthritis: □Yes □No

There is a bi-directional connection between rheumatoid arthritis and gum disease. If you have arthritis you are at an increased risk for gum disease. Emerging research suggests that eliminating any gum disease and then keeping it at bay can lessen the crippling effects of arthritis.

Cardiovascular Disease □Yes □No If yes, please specify _____

Gum disease is now a recognized risk factor for heart disease. If your gums are inflamed, bacteria from your mouth can get into your blood stream & lodge in your heart vessels. Finding out if you have gum disease & the keeping it at bay over your lifespan can lower your risk for heart disease & stroke.

GENETICS

Family History of Gum Disease: □Yes □No □ Don't know. If yes, who _____

Some people are genetically prone to developing gum disease even if they take care of their mouths. Identifying these individuals and getting them into early intervention treatment may help them keep their teeth for a lifetime.

Family History of Diabetes: □Yes □ No If yes, who? _____

Diabetes is a well-known risk factor for gum disease. Research is confirming that when left untreated gum disease makes it harder for you to control your blood sugar. Elimination of gum disease can improve your blood sugar control.

Family History of Alzheimer's Disease: □Yes □No □ Don't know.

Gum disease has been linked with an increased chance for developing Alzheimer's Disease later in life. If you have a family history, you are already at increased risk. Keeping gum disease at bay over your life span can lower your risk for developing Alzheimer's Disease.

STRESS

Is your stress level high? □Yes □No

Stress is a well-known risk factor for gum disease. Life altering events (loss of job, divorce, death in family, moving) can be particularly strong factors for Gum disease. Are you currently going through any life altering events? □Yes □No If yes, what? _____

OVERWEIGHT

Are you overweight? □Yes □No List height _____ List weight _____

Being overweight is now recognized as a strong risk factor for gum disease. Obesity and gum disease are both risk factors for heart disease and diabetes. Thus, if you're over your ideal weight it is vitally important for you to eliminate any gum inflammation to lower your risks for more serious health problems.

MEDICATIONS

Some drugs can affect your oral health are you taking any of the following: □ Taking 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

Coast DENTAL CENTRE

DENTAL HISTORY

Former Dentist Name: _____ Last dental visit: _____

I see my dentist every □3 □4 □6 □12 months □ not routinely

I would rate the condition of my mouth as? □Excellent □Good □Fair □Poor

Immediate Concern: _____

Personal History		**Yes**	**No**
1.	Have you ever had an unfavourable or a complication(s) from past dental experience?		
2.	Have you ever had trouble getting numb or experienced a reaction to local anesthetic?		
Cosmetics			
3.	Is there anything about the appearance of your teeth that you would like to change?		
4.	Have you ever whitened (bleached) your teeth?		
5.	Are you interested in Whitening, Veneers, Crowns, Invisalign, Braces, White fillings?		
6.	Are you self-conscious about your teeth?		
7.	Have you been disappointed with the appearance of previous dental work?		
Function			
8.	Do you have problems chewing gum and/or hard foods?		
9.	Have your teeth changed in the last 5 years, become shorter, thinner, worn or darker?		
10.	Are your teeth crowding or developing spaces?		
11.	Are there areas in your mouth where food gets trapped?		
12.	Do you bite your nails or hold foreign objects with your teeth? (i.e. pens, pencils, nails)		
13.	Do you have problems with your jaw joint/TMJ? (pain, sounds, limited opening, locking, popping)		
14.	Do you wear or have you worn a night appliance/guard or sports guard?		
15.	Have you ever had jaw surgery? If yes, when?		
16.	Have you had orthodontic treatment? If yes, when?		
17.	Do you have implants or dentures?		
18.	Have you had extractions? Where and When?		
19.	Have you had any root canals?		
20.	Do you clench or grind during the day or been told you do so at night?		
Comfort			
21.	Have you had cavities within the past 3 years? Have you ever had a toothache?		
22.	Have you ever had cracked fillings, and broken, chipped or cracked teeth?		
23.	Do you have tension headaches or sore teeth?		
24.	Do you experience a burning sensation in your mouth?		
25.	Are any of your teeth sensitive to hot, cold, sweets or pressure?		
26.	Do you bite your cheeks?		
27.	Do you breathe through your mouth? Are your lips always chapped? Do you have dry mouth?		
28	At rest is your tongue on the roof of your mouth?		
Longevity			
29.	Do you have or been told you have gum disease?		
30.	Have you had gum surgery? If yes, where and when?		
31.	Have your gums receded? If yes, where and when?		
32.	Are your teeth getting loose?		
33.	Do your gums bleed when brushing, flossing or eating?		
34.	Have you ever noticed an unpleasant taste or odour in your mouth?		
35.	Has anyone ever told you that you have bad breath?		
36.	Do your gums and or teeth hurt during cleanings?		
37.	Have you ever had your teeth cleaned with freezing?		
38.	Do you wear any oral piercings (extra or intraoral)? Have you ever? □Yes □No		
39.	Have you had dental work done in a country other than the U.S. or Canada?		

What is your current home care regime? Floss □Yes □No 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?_____

Date: _____ Patient Signature: _____

Coast DENTAL CENTRE

Insurance Policy

Patient's responsibilities

- Dental plans are not customized to your individual dental health needs and may or may not cover all your treatment needs.
- Know what your plan covers including services, percentage coverage and/or treatment limits. Ask your plan purchaser/plan provider for details.
- You must pay the co-payment, the portion not covered by the plan.
- Lab fees may also factor into your treatment depending on the type of dental procedure required. Costs are determined by an outside lab and may or may not be covered by your plan. Any costs not covered by your plan are your responsibility.
- When changes in policies, carriers, and termination of plans occur insurance companies **DO NOT INFORM DENTAL OFFICES**. It is the patient's responsibility to know and advise us when these changes occur and again are ultimately responsible for any balances that are incurred from services rendered, as a result of the above.

Dentist's responsibilities:

- Provide treatment recommendations based on your dental health care needs; this may, or may not, be covered by your plan. Coast Dental Centre recommends treatment to improve and maintain your oral health
- Submit a pre-determination to your plan provider, if you are concerned about costs. This will provide an estimate of what your dental plan will benefit prior to treatment.
- We bill insurances as a ***courtesy***. However, any portion not covered by insurance is the patient's responsibility.

Although we have extensive knowledge of insurance benefits, it is to your benefit to READ your employee handbook and understand your covered services. Ultimately, it's a contract between you and your employer. We encourage you to talk to your insurance carrier regarding the coverage details of your plan. This will avoid any disappointments regarding changes and or the decline in payment of services.

In some cases, insurance carriers only correspond with their members; in this case, you need to inform Coast Dental Centre so that we can assist you in understanding these correspondences.

As a patient of Coast Dental Centre, I have read and understand the above insurance policy. Any treatment that my insurance does not pay or exceeds the limits of my plan will be my responsibility and billed directly to me.

Date: _____ Patient Signature: _____

Coast DENTAL CENTRE

Patient Agreement

Welcome to Coast Dental Centre. We are pleased that you have chosen us to be your provider of quality dental care.

To ensure that we can provide the best customer service to our patients the following policies are in effect:

- Any change to your address, phone number, email address and insurance coverage must be provided the day of treatment.
- Changes to medical/dental history particularly in regard to medications, allergies, recent hospitable visits, and glucose & 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 requires two working days' notice for any changes or cancellations of scheduled appointments, or a $90 fee will be applied to your account.

Payment Options

Coast Dental Centre is pleased to offer you the following payment options:

☐ **Option 1: You do not have insurance benefits.**
Payment is due in full on the day treatment is rendered. We accept Cash, Debit, Visa and MasterCard.

☐ **Option 2: You pay for the entire treatment on the service date and your insurance reimburses you.**
You may prefer to pay for your dental work on your treatment day and have your insurance company reimburse you directly. Coast Dental Centre will assist you in submitting the necessary documents to your insurance carrier.

☐ **Option 3: You pay your expected co-pay portion and your insurance reimburses our office.**
This option required you to leave your credit card information on file in case there is a portion not covered by your benefits plan. We will submit your insurance claim directly to your insurance provider and you will pay the balance of the dental fee as "indicated" by your insurance provider. Once your insurance provider has paid us their portion, Coast Dental Centre will process any outstanding balance to your credit card. As a courtesy, prior to processing your credit card, Coast Dental Centre will contact you if the outstanding balance not benefited by your insurance is greater than $90.

☐ I have read and agree to the policies as outlined above.

Date: _____ Patient Signature: _____

Coast DENTAL CENTRE

PRIVACY STATEMENT FOR PATIENTS & CONSENT FORM

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 coastdentalclinic@outlook.com with ATTN: OFFICE MANAGER in the subject line.

Coast DENTAL CENTRE

PRIVACY STATEMENT FOR PATIENTS & CONSENT FORM

I hereby give Coast Dental Center permission to speak with or provide written or electronic information to my significant other/ spouse/ parent/ guardian about any information that is needed in the opinion of the Coast Dental Center. Name of Third party(s):

_____	_____	_____
Name	Relationship to you	Phone No. (if named individual is not a patient)
_____	_____	_____
Name	Relationship to you	Phone No. (if named individual is not a patient)

☐ I give permission to Coast Dental Centre to contact my insurance provider to receive benefit details breakdown, 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.

☐ I consent to have my dental records, including periodontal charting and x-rays, insurance information and personal information shared with other dental offices when being referred for treatment.

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

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

☐ I have read and agreed to all of the above policies as outlined.

Patient Name: _____ Date: _____

Patient Signature: _____