Kelowna Family Dental

Taking Care of your Smile!

Patient Information & Health History

Name: Miss, Ms., Mrs., Mr., Dr., Surname:__________________First:__________________Middle Initial:____

Preferred Name: _________________ **Gender:** M / F **Birthdate:** ________________

Address:______________________________________ **City:** _________________ **Postal Code:**_______

Home Phone:__________________ **Cell Phone:**_________________ **Work Phone:** _________________

Email:____

Occupation:______________________________ **Employer:** ___________________________________

Emergency Contact: ___________________________________ **Phone:**__________________________

Drivers License #:___________________________

Dental Insurance: □ Yes □ No **Insurance Company:** _____________________________________

Group/Policy #: _________________ Certificate/ID#:__________________ Dep#:______________

Policy Holder:____________________ Deductible: _________ Yearly Limit:__________________

How did you hear about our office:____

If it is someone we know, we would love to thank them so please provide their name.

Medical History

Physician: ____ **Phone #:** ____________________________

Are you currently being treated for any illnesses? □ Yes □ No

If yes, please provide details: ____

Are you allergic to anything? □ Yes □ No If yes, please list:_____________________________________

Have you been advised to take pre-medication antibiotics prior to dental treatment □ Yes □ No

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

Rheumatic Fever	□ Yes □ No	Congenital Heart Defect/Murmur	□ Yes □ No
Circulatory Problems	□ Yes □ No	Hepatitis/Jaundice/Liver Disease	□ Yes □ No
Kidney Disorder	□ Yes □ No	High/Low Blood Pressure	□ Yes □ No
Tuberculosis	□ Yes □ No	Asthma/Lung Problems	□ Yes □ No
Sinus Problems	□ Yes □ No	Nervous Disorders/Seizures/Fainting	□ Yes □ No
Infectious Disease	□ Yes □ No	Bleeding Disorder	□ Yes □ No
Arthritis	□ Yes □ No	Diabetes	□ Yes □ No
Headaches	□ Yes □ No	Artificial Joints or Valves	□ Yes □ No
Heart Disease	□ Yes □ No	Cancer/Chemotherapy/Radiation	□ Yes □ No
Contact Lenses	□ Yes □ No	Women: Currently Pregnant	□ Yes □ No
COVID-19	□ Yes □ No		

Please see next page

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Are you currently taking any medications □ Yes □ No List:_______________________________________

____

Do you smoke □ Yes □ No **Do you grind/clench your teeth** □ Yes □ No

Is there any additional information related to your health that has not been addressed above?

____

Signature of patient or parent/guardian______________________________ **Date:**________________

<u>Dental History</u>

Main Dental Concern: ____

Previous Dentist: ___________________________ **Date of Last Exam:** ___________________________

Do your gums bleed when brushing/flossing □ Yes □ No

Are your teeth sensitive to hot/cold/sweets □ Yes □ No

Do you have any tooth pain □ Yes □ No

Do you have any sores/lumps in your mouth □ Yes □ No

Do you have any jaw problems □ Yes □ No

Do you ever notice an unpleasant taste or bad breath □ Yes □ No

Have you had difficult extractions before □ Yes □ No

Have you had prolonged bleeding after extractions □ Yes □ No

Do you snore or have sleep apnea □ Yes □ No

Have you ever wanted straighter teeth □ Yes □ No

How often do you: brush your teeth ________________ **floss your teeth** ___________________________

Do you have any other dental concerns or history not addressed above? _______________________________

____

Is there anything about your mouth or smile that you wish you could change? ___________________________

____

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this, we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

Signature of patient or parent/guardian___________________________ **Date:**_____________________

I understand and acknowledge that I am solely and ultimately responsible for my account, and that if I have dental insurance, and although this office may submit claim forms on my behalf, I am responsible for any unpaid claims, or portions thereof.

Signature of patient or parent/guardian___________________________ **Date:**_____________________