Kelowna Family Dental
Taking Care of your Smile!

Patient Information & Health History

Name: Surname:_____ First:_____ Middle Initial:____

Preferred Name: _____ **Gender:** M / F / O **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#:_____

Policy Holder:_____ Policy Holder Birthdate: _____

Policy Holder Employer: _____ Policy Holder Address (if different): _____

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 (please circle)	□ 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	Currently Pregnant	□ Yes □ No
COVID-19	□ Yes □ No		

Please see next page

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Taking Care of your Smile!

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:**_____

Dental History

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	□ Yes □ No
Do you 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:**_____

We will contact you to confirm your appointments. We require 2 business days notice to reschedule your appointment.