VIC247 Dental Hygiene 250.744.9462
vic247dental@gmail.com | 878 Falkland Road, Oak Bay BC V8S 4L8

NEW PATIENT FORM

Today's Date: _____ Patient Name: _____

Gender / Pronouns: _____ Birthdate: _____

(If applicable, patient's parent/guardian name): _____

Address: _____

Cell Phone: _____Other Phone: _____

E-Mail: _____ Referred By: _____

Emerg. Contact: _____ Their Phone: _____ Relationship: _____

Your Doctor: _____ Doctor's Phone: _____

Your Dentist: _____ Dentist's Phone: _____

INSURANCE INFO (IF APPLICABLE):

Name of Insurance Policyholder: _____ THEIR Birthday: _____

Insurance Company Name: _____

Group/ Contact #: _____ Subscriber/Cert #:_____

MEDICAL HISTORY:

Are you being treated by a doctor for anything? _____LAST MEDICAL CHECKUP:_____

Past 2 years: hospital visits/serious illness? _____

Prescriptions: _____

ALL ALLERGIES: _____

HAS A DR EVER ASKED YOU TO TAKE ANTIBIOTICS BEFORE DENTAL WORK? _____WHY? _____

HISTORY of HEART VALVE ISSUES or ENDOCARDITIS? (surgery, prosthetic/deformed valve) _____

PLEASE CHECK ALL THAT APPLY:

- ☐ acid reflux or GERD
- ☐ addiction issues
- ☐ Alzheimer's /memory prob
- ☐ anemia
- ☐ angina/chest pain
- ☐ anorexia/bulimia
- ☐ anxiety / dental phobia
- ☐ arthritis
- ☐ asthma
- ☐ back/neck trouble
- ☐ bleeding problems
- ☐ blood pressure – HIGH/low
- ☐ cancer PAST or PRESENT
- ☐ cold sores (oral herpes)
- ☐ COPD (emphysema)
- ☐ diabetes TYPE 1 – TYPE 2
- ☐ epilepsy / seizures
- ☐ fainting / dizziness
- ☐ fibromyalgia
- ☐ heart disease
- ☐ heart attack - date:
- ☐ heart pacemaker
- ☐ hepatitis A – B – C
- ☐ HIV / AIDS
- ☐ joint replacement
- ☐ kidney disease
- ☐ liver disease
- ☐ lung disease
- ☐ lupus
- ☐ organ transplant
- ☐ Parkinson's
- ☐ PREGNANT? Due: _____
- ☐ radiation / chemo (current)
- ☐ rheumatic fever (past)
- ☐ sinus problems
- ☐ sleep apnea
- ☐ smoker
- ☐ stroke / TIA date: _____
- ☐ thrush
- ☐ thyroid problems
- ☐ tuberculosis
- ☐ OTHER PROBLEM: (describe below)

Patient Name: _____

DENTAL HISTORY:

Last Dentist Visit (month/year): _____ Where? _____

Last X-Rays (month/year): _____ Last Cleaning (month/year): _____

Any special preferences during dental cleaning?_____

Sensitive teeth? _____ To what? _____

Past problems with dental anesthetic (freezing)? _____Are you a smoker? How much?_____

Have you ever visited a periodontist? ("gum specialist") : _____

Have you ever had braces? _____ Have you ever had implants? _____

Do your gums bleed? _____ Do you have a denture? _____

Are any teeth loose? _____ Any missing teeth? _____

Do you experience dry mouth? _____ Bad breath / bad taste? _____

Right- or Left-handed? _____ Have wisdom teeth been removed? _____

Any jaw (TMJ) problems? _____

Any spaces where food catches regularly? _____

How do you feel about your smile? _____

What would you change about your smile if you could? _____

How often do you brush? _____ Floss? _____ Other? _____

What is your biggest difficulty with your home oral care routine? _____

_____

Do you have any concerns or fears that have not been mentioned yet? _____

_____

I, the undersigned, understand that providing a complete medical and dental history is important to my oral care. I certify the information in this document is correct to the best of my knowledge, and I understand that any omissions may affect the ability of the hygienist to provide appropriate care. I consent to release my oral health information (including images) to the dentists or other physicians I have listed on this document. I authorize this hygiene office to perform diagnostic procedures/assessments required to determine treatment. I understand that treatments/fees will be explained to me and accepted by me before being performed. I assume all responsibility for all fees associated with diagnostic and therapeutic procedures for myself and my dependents. I understand that while VIC247 Dental Hygiene can assist with my insurance submissions, I am ultimately responsible for the timely payment of all the fees on this account for myself (and my dependents), regardless of what my insurance company pays. I understand all accounts are due the day treatment is rendered. I agree to give 24 hours notice to cancel appointments, and I agree that there may be a $50 fee for missed appointments with less than 24 hours notice.

_____ _____ _____

Print Name Patient (or Guardian) Signature Date