Medical History

Patient Name: _____ Gender: ☐Female ☐Male ☐Other ☐Prefer not to answer

Guardian's Name (if patient is a minor): _____

Date of Birth M:_____ D: _____Y:_____ Email: _____ Occupation:_____

Home: _____ Mobile: _____ Work (optional): _____

Address including postal code: _____

Family Doctor: _____ Office phone #:_____

Name of emergency contact: _____Phone #:_____

If English is not your first language, 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: _____

Would you like to receive electronic reminders and communication? If yes, ☐Email ☐Text ☐No

What is your estimate general health? ☐Excellent ☐Good ☐Fair ☐Poor

Do you or have you ever had:

Hospitalization for illness or injury: ☐Yes ☐No If yes**,** please provide details: _____

Allergies: ☐Aspirin ☐Ibuprofen ☐Acetaminophen ☐Codeine ☐Penicillin ☐Tetracycline ☐Local anesthetic

☐Metals (nickel, gold, silver) ☐Fluoride ☐Sulfa ☐Erythromycin ☐Latex ☐Other_____

☐No known allergies

Joint Replacement: ☐Yes ☐No If yes what joint? _____ When? _____

Female: ☐Osteoporosis? ☐Yes ☐No If yes, are you taking medication? ☐Yes ☐No

Select all conditions that apply to you

☐ *Artificial Heart Valves*

☐ *Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits*

☐ *A history of infective endocarditis*

☐ Heart Attack - Date:_____

☐ Cardiac Stent(s) - Date:_____

☐ Stroke - Date:_____

☐ High or Low Blood Pressure

☐ Anemia or other blood disorder

☐ Prolonged bleeding due to slight cut

☐ On blood thinners i.e. Coumadin, Adult Aspirin, Plavix (INR #: _____)

☐ Emphysema

☐ Tuberculosis

☐ Asthma: Do you carry an inhaler with you?

☐ Thyroid Disease

☐ Kidney Disease

☐ Liver Disease

☐ Jaundice

☐ Cancer - Type:_____

☐ Radiation/Chemotherapy

☐ Male Only: Prostate disorders

☐ *A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention within the last six months*

☐ *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 cardiac transplant that developed a problem in a heart valve*

☐ Emotional Disorders, Depression, Psychiatric treatment

☐ Epilepsy, convulsion (seizures)

☐ Muscular dystrophy, multiple sclerosis

☐ Neurologic problems (ADD)

☐ Hepatitis - Type:_____

☐ Breathing or Sleep Problems (i.e. snoring, sinus)

☐ Unexplained sore throat, feeling like something is caught in throat or chronic hoarseness

☐ HIV/AIDS

☐ Colitis/Crohns

☐ Eating Disorder (Bulimia, Anorexia Nervosa)

☐ Lupus

☐ Cold Sores

☐ Head or Neck injuries

☐ Lumps or swelling in the mouth or neck area

☐ Digestive disorders (i.e. Gastric reflux)

☐ Drug Dependency - Type:_____

☐ Consumer of alcohol – number of times per week:_____

☐ None applies to me

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 test: _____. What is your current HbA1c level? _____
(Diabetes control: Good below 7% A1c/140 mg/dL Fair 7-9% A1c/140-220 mg/dL Poor above 9% A1c/>330mg/dL)
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 ☐Don't know If yes, who? _____
Family History of Alzheimer's disease: ☐Yes ☐No ☐Don't know If yes, who? _____

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 Height: _____ 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 If yes, are you using an ☐Upper nightguard ☐Lower nightguard or ☐None

***** 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.***

Dental History

I would rate the condition of my mouth as? ☐Excellent ☐Good ☐Fair ☐Poor
What is your current care regime?
Floss: ☐Yes ☐No If yes, how often?_____
Waterpik: ☐Yes ☐No If yes, how often? _____
Mouth rinse: ☐Yes ☐No If yes, how often? _____
What type of mouth rinse? ☐with alcohol ☐without alcohol ☐with fluoride ☐without fluoride
Tooth Brush: ☐Manual ☐Electric How often?_____
Other home care products: _____

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 due to pain/discomfort?
☐	☐	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 on what your dental plan covers. Please take your time to review our direct-billing policy:

1. **Insurance plans do not cover ALL dental services and are not tailored to suit individual oral care needs**. If your clinician recommends a treatment that is not a benefit on your plan, this will always be discussed with you thoroughly.
2. Dental claims will be submitted by our office and only your co-pay or expense not covered by your plan will be collected.
3. **It is the patient's responsibility to cover any costs that are not paid by your dental plan**, including yearly deductions. Financing can be arranged if needed.
4. Our receptionists will assist in obtaining your insurance breakdown. These details allow your clinician to discuss your dental treatment comprehensively. Unfortunately, not all insurance companies provide this information, so we recommend our patients become familiar with their individual plan coverage, as it is ultimately your responsibility as a plan member.
5. **You must update our reception team of any changes to your insurance coverage status.** Insurers do not relay this information to the clinic, and we will assume that your dental plan is active, unless otherwise advised by you. Fees incurred due to plan termination/ changes in plan policy will result in out-of-pocket expense.
6. Before any major treatment, we will submit a predetermination to check your coverage and you will be provided with an estimate. We do our very best to provide the most accurate information, but please understand that estimates are only an approximation of costs. While we do our due diligence in providing accurate breakdown of costs and payments, there is the rare occasion where actual treatment may differ from the original estimate.
7. In some instances, we may request you to sign a claim document or forward us a copy of correspondence that is not available to our office. Due to sometimes lengthy process times, we request that you respond promptly to avoid delays or exceeding submission deadlines.

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

_____ I do not have dental insurance.

Please provide dental insurance details below:

Primary Insurance company name: _____

Plan 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: _____

Plan member's birthdate: M:_____ D: _____Y:_____

Secondary Insurance company name: _____

Plan 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: _____

Plan member's birthdate: M:_____ D: _____Y:_____

Cancellation Policy

We understand that things can come up and that you may need to change your appointment. We ask that you contact our office with a minimum of **2 business days' notice**. A $90.00 fee is charged if you do not show up or request to change your appointment with less than 48 hours' notice. Please note that this fee is not covered by any insurance companies. If appointments are repeatedly missed or short-cancelled, you will no longer be able to book in advance or, in some instances, your records may be closed. *If, as a new patient, you do not show up to your confirmed appointment without any prior notice, your appointment will not be rescheduled.*

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

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	Provide phone no. if named individual is not our patient
_____	_____	_____
Name of spouse/parent/legal guardian	Relationship to you	Provide 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 submitted claims.

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

_____ (initials) I am aware that I can opt-out of the e-mail and text reminders at any time by notifying the front staff.

_____ (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: _____

Coast DENTAL CENTRE

Patient Copy

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 e-mail to info@coastdental.ca.