Peachland
dental centre

PATIENT INFORMATION AND HEALTH HISTORY

Date: _____

Name: _____ M___ F___ Birthday:_____
Last First Month Day Year

Mailing Address: _____
Number Street City

Province: _____Postal Code: _____Phone: _____ Cell #:_____ Work: _____

Email: _____ Driver's Licence/Sin #: _____

Can we email or text you to confirm your appointments? Circle one: YES NO email only____text only _____ both____

KIDS ONLY: Mother: _____ Father: _____

Who may we thank for referring you to our office?_____

DENTAL INSURANCE

Primary Insurance

Name of Insured Member:_____

Member's Birthday:_____

Name of Insurance Company:_____

Employer: _____

Secondary Insurance

Name of Insured Member:_____

Member's Birthday:_____

Name of Insurance Company:_____

Employer: _____

MEDICAL HISTORY

Physician:_____ Date of last exam:_____

Are you allergic to any medications? Please select below:

- ☐ Aspirin
- ☐ Penicillin
- ☐ Sulfa
- ☐ Erythromycin
- ☐ Tetracycline
- ☐ Codeine
- ☐ Sedatives
- ☐ Dental Anesthetic (Epinephrine)
- ☐ Latex
- ☐ Metals
- ☐ Ibuprofen
- ☐ Acetaminophen
- ☐ Other (please list below):

_____

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

- ☐ Arthritis
- ☐ Artificial Heart Valves
- ☐ Infective Endocarditis
- ☐ Cardiac Transplant
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone-Steroid Treatment
- ☐ Diabetes Type I or II
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hemophilia
- ☐ Hepatitis A B C
- ☐ Jaundice
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Fainting
- ☐ Sleep Apnea
- ☐ Tobacco use
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Acid Reflux
- ☐ Head or Neck injury
- ☐ Emphysema
- ☐ Blood Thinning Medication
- ☐ Premedication
- ☐ Vitamins
- ☐ Birth control
- ☐ Dental Anxiety

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WOMEN ONLY- Are you possibly pregnant? _____ How Many Weeks? _____

If taking medications, supplements, and/or vitamins, please list below:

_____

_____

Is there any additional information regarding your health we should know about as your dentist?

_____

DENTAL HISTORY

Main Dental Concern: _____

Have you had any previous problems with dental work?	☐ Yes ☐ No
Do you have, or have you had bleeding upon brushing or flossing?	☐ Yes ☐ No
Do you clench or grind your teeth?	☐ Yes ☐ No
Do you have frequent blisters or sores on your lips?	☐ Yes ☐ No
Do you ever notice unpleasant taste or bad breath?	☐ Yes ☐ No
Do you experience chronic or frequent headaches?	☐ Yes ☐ No
Are you happy with your smile?	☐ Yes ☐ No

If no, what would you change? _____

EMERGENCY CONTACT INFORMATION

Please list the names and telephone numbers of two people that we may contact in case of an emergency.

Name: _____ Phone number: _____

Name: _____ Phone number: _____

FINANCIAL POLICY

For your convenience, we accept Visa, MasterCard, and Debit. Payment for treatment is due at the time of service rendered.

INSURANCE POLICY

If you have dental benefit coverage, it should be considered as a means of assisting you with the cost of maintaining your oral health, which is connected to your overall health. Since the Privacy Act was introduced in 2004, insurance companies often will not share the details of your plan with us. Our office bills over 50 different insurance companies and policies, each having their own rules and regulations. This will affect benefits paid, deductibles and maximum yearly limits. Please be aware of what your plan limitations are and share them with us. Out of province plans will be handled as reimbursement plans only. If you have any questions our administrative assistants will be happy to assist you.

MISSED APPOINTMENT POLICY

We kindly request 48 hours notice to reschedule an appointment. Same day cancellation and no show appointments will be subject to a charge of $75.00.

Patient or Parent Signature: _____

Date: _____

PATIENT INFORMATION AND HEALTH HISTORY

PRIVACY, DISCLOSURE, & CONSENT

TO: Peachland Dental Centre and Peachland Health Services

Information for our Patients

At Peachland Dental Centre, all professional dental services are performed by licensed members of the College of Dental Surgeons of British Columbia ("Dental Professionals"), and all institutional health care services are performed independently by Peachland Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Peachland Dental Centre and Peachland Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Peachland Health Services.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Peachland Dental Centre; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Peachland Dental Centre to provide the services you are requesting).

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided and accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Peachland Dental Centre, Peachland Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Peachland Dental Centre and Peachland Health Services in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Peachland Dental Centre and Peachland Health Services are relying upon the information which I have provided being accurate and complete.

_____	_____	_____
Print Name of ☐Patient ☐Parent ☐ Guardian	Signature of ☐Patient ☐Parent ☐ Guardian	Date
_____		_____
Reviewed by Peachland Dental Centre		Date