NEW PATIENT FORM

OUR MISSION: At Mission Creek Dental Centre, we are committed to giving you the best care and excellence in dentistry. We strive to explain treatment options to you in language that you understand, and we want you to be well educated in your oral health after visiting our office. If you have any questions about our services or your oral health needs, please feel free to ask any of our knowledgeable team members.

How did you hear about us?

- Personal Referral or Business Referral? If so, please indicate the person's name so we can personally thank them. _____
- Advertising? If so, please circle which type:
  - Yellow Pages or Infotel
  - Google (or other search engine)
  - Signage
  - Newspaper

ABOUT YOU

Today's Date: _____

Last Name: _____ First Name: _____Middle Initial:____

Date of Birth: _____ Age: _____

Mailing Address: _____ City _____

Province: _____Postal Code: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____Employer: _____

SIN(optional): _____ Care Card Number: _____

Spouse/Common-Law Name:_____Spouse/Common Law Birthday:_____

Emergency Contact: _____Phone Number: _____

CIRCLE WHICH APPOINTMENT REMINDER YOU PREFER: Email Phone Call Mailed Card

METHOD OF PAYMENT

Do you have dental insurance? Yes No

Carrier: _____ Policy #: _____Group #:_____

Do you have secondary dental insurance? Yes No

Carrier: _____ Policy #: _____Group #:_____

Please sign Authorization to Release Info and Assignment of Benefits:

I certify that I, _____, (or my dependent) have (has) dental insurance coverage and assign directly to Dr. Kim all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or his staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

Disclaimer: Dental Insurance is a private legal agreement between you and the insurance company. Mission Creek Dental submits claims on your behalf but holds no responsibility for limitations or procedures not covered. Insurance companies do not release information about the the details of your plan to our office without your consent.

DENTAL/MEDICAL HISTORY

Date of last visit to a dentist: _____ Reason: _____

Name and location of last dental office visited: _____

Are you presently in dental pain? Yes No

What is your immediate dental concern? _____

- Are your teeth sensitive to: **(Please circle)**
  - a) Hot/cold? Yes No
  - b) Sweets? Yes No
  - c) Biting Pressure Yes No
- Have you had gum surgery? Yes No
- Do your gums bleed when brushing? Yes No
- Have you ever had any abnormal bleeding or other problems associated with previous dental extractions or surgery? Yes No
- Have you ever seen a dental specialist (endodontist, periodontist?) Yes No
- Do you have pain or stiffness in your jaw, neck or face? Yes No
- Do you have any oral habits such as clenching, grinding, or nail-biting? Yes No
- Do you wear dentures? Yes No

If so, what type: _____

- Do you wear a night guard or have you ever worn one? Yes No
- Have you had a reaction to local anaesthetic, fluoride or dyes? Yes No
- Are you aware if you grind your teeth while sleeping? Yes No
- Do you avoid chewing in any part of your mouth? Yes No
- Have you had professional tooth brushing or flossing instructions? Yes No
- How often do you brush your teeth per day? _____
- How often do you floss your teeth? Daily Weekly Monthly Never
- Do you have any health problems? Yes No

If so, please specify: _____

- Name of Physician: _____
- Date of last health exam: _____
- Are you presently taking any medication (including oral contraceptives) Yes No

Name of drug and purpose: _____

Are you allergic to any medication? Yes No

- **If so, please specify:**

_____

_____

_____

_____

To the best of your knowledge, tick off any of the following which you have had or have at present:

Heart Failure		Diabetes (Type I, Type II)	
Heart Disease or Heart Attack		Family History of Diabetes	
Angina		Thyroid Disease	
High Blood Pressure (last date of reading) _____		Cancer (list type of cancer)	
Heart Murmur		Chemotherapy	
Rheumatic Fever		Leukemia	
Congenital Heart Lesions		Rheumatism	
Scarlet Fever		Cortisone Steroid Medication	
Artificial Heart Valve		Glaucoma	
Heart Pacemaker		HIV/AIDS	
Heart Surgery		Hepatitis (A, B or C)	
Artificial Joint (Knee or hip replacement)		Liver Disease	
Anaemia		Jaundice	
Blood Disorder		Blood Transfusion	
Stroke		Drug Addiction	
Kidney Problems		Hemophilia	
Ulcers		Sexually Transmitted Infections	
Emphysema		Cold Sores	
Prolonged Cough		Epilepsy of Seizures	
Tuberculosis (TB)		Fainting or Dizzy Spells	
Asthma		Psychiatric Treatment	
Hay Fever		Extreme Nervousness	
Sinus Trouble		Frequent Severe Headaches	
Allergies or Hives		Pain of the Jaw Joints	
Sleep Apnea		(Women) Are you pregnant?	

If not listed, please describe any health concerns you may have at this time:

_____
_____
_____
_____
_____
_____
_____

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential to be dangerous to my health. I will keep the dental office updated with any changes to my health and/or medications and allergies.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. Privacy of our patient's personal information is important to us. We have established and implemented a variety of security measures to properly manage and safeguard your personal information from loss, theft and unauthorized access.

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 clinical records, x-rays, study models, photographs of your teeth, mouth, smile, face and general health information obtained from a medical history review, insurance information, phone numbers and addresses. Clinical information, photographs, and x-rays may also be used for long-term follow-up, research purposes, anonymously on our website smile gallery, as well as for education purposes.

Your personal information shall only be disclosed to those who have a need to know and specific information disclosed shall be restricted to only that information relevant to what the recipients need to know (referring dentists, other dental specialists, physicians, dental laboratories, and dental insurance companies).

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and that I may be billed for this remaining balance. I also understand that if I require any major dental treatment that requires lab services, that I may be required to pay for these services at the time of the impressions appointment. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

_____ _____

Signature of Patient/Parent/Guardian Date Signed

_____

Relationship to Patient

Mission Creek Dental Centre
Dr. Daniel J. Kim
400-575 Osprey Avenue
Kelowna, BC V1Y 5A7
(250) 869-4138 office
(250) 869-4038 fax