DENTISTS RUS

*Welcome to our office!*

**Select Preferred Location**

Please Make a Selection

## New Patient Information Form

**Patient Name**:_____ **Date of Birth**:_____/_____/_____
**First** **Initial** **Last Name** **Day / Month / Year**

Home No.: (___) _____ Mobile: (_ __) _____ Work No.: (____) _____

Email Address:_____ Care Card Number:_____

SIN Number:_____ Driver's License Number:_____
(*SIN and Driver's Number is required to verify identity and prevent fraud*)

Residence Address:_____ City:_____ Postal Code:_____

Emergency Contact Name: _____ Emergency Contact No.:_____
Family Doctor:_____ Family Doctor No:_____
Occupation:_____

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

**Insurance Information:**
**Name of the Insured:_____ Date of Birth:_____**
**Name of the Insurance Carrier:_____ Policy No.:_____ ID/Cert no.:_____**

### General Release/Authorization

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize the dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for the treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment and /or dental diagnostic procedure.

I hereby assigned my benefits, payable from claims submitted electronically, to New Westminster Skytrain Sedation and General Dentistry and authorize payment directly to the office. The authorization shall continue in effect until the undersigned revokes the same.

I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described, to the named dental office.

☐ I authorize and consent Sedation Dental Group (DentistsRus.ca) to send promotional and periodic company update to my email address provided.

**Signature**:_____**Printed Name**:_____**Date**:_____
**For Minors:**
**Parent signature**:_____ **Printed Name**:_____**Date:**_____

## Medical History

**Circle any of the following that apply to you**.

1. Are you having pain or discomfort at this time? Yes no
2. Do you feel nervous about having dental treatment? Yes no
3. Have you ever had a bad experience in the dental office? Yes no
4. Have you been a patient in a hospital during the past two years? Yes no
5. Have you been under the care of a medical doctor during the past two years? Yes no
6. Have you taken any medicine or drugs regularly during the past two years? Yes no
7. Are you allergic to (i.e itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine or any drugs or medications? Yes no
8. Have you ever had any excessive bleeding requiring special treatments? Yes no
9. Have you ever taken diet medication? Which medication did you use?_____ _____ Yes no
10. Do you have Osteoporosis or have you taken the following: Fosomax, Didronel, Boniva, Aredia, Actonel, Skelid or Zometa (these are drugs used to treat Osteoporosis. They can cause major problems for surgery procedures). Yes no

**Please circle y for yes for any of the following that apply to you. Circle n for no if you have never had this condition or disease.**

| | | | |
|---|---|---|---|
| y n Heart Failure | y n Emphysema | y n Hepatitis A (Infectious) | y n HIV / AIDS |
| y n Heart Attack (MI) | y n Cough | y n Hepatitis B (serum) | y n Nervousness |
| y n Angina Pectoris | y n Tuberculosis (TB) | y n Hepatitis C | y n Asthma |
| y n Liver Disease | y n Stroke | y n High Blood Pressure | y n Heart Murmur |
| y n Hay Fever | y n Ulcers | y n Psychiatric Treatment | y n Sinus Trouble |
| y n Yellow Jaundice | y n Rheaumatic Fever | y n Liver Transplant | y n Glaucoma |
| y n Scarlet Fever | y n Allergies or Hives | y n Drug or Alcohol Abuse | y n Bruise Easily |
| y n Diabetes | y n Hemophilia | y n Artificial Heart Valve | y n Thyroid Disease |
| y n Pain in Jaw Joints | y n Heart Pacemaker | y n Mitral Valve Prolapse | y n X-Ray Treatment |
| y n Genital Herpes | y n Arthritis | y n Venereal Disease (Syphillis, Gonorrhea) | |
| y n Heart Surgery | y n Cold Sores | y n Kidney Trouble | y n Artificial Joint |
| y n Rheaumatism | y n Anemia | y n Cortisone Medicine | y n Sickle Cell Disease |
| y n Blood Transfusion | y n Congenital Heart Lesions | y n Chemotheraphy (Cancer, Leukemia) | |
| Y n Fainting or Dizzy Spells | | | |

Do you smoke? YES No Do you use recreational drugs? YES NO

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest or shortness of breath, or because you are very tired? Yes no
12. Do your ankles swell during the day? Yes no
13. Do you use more than 2 pillows to sleep? Yes no
14. Have you lost or gained more than 10 pounds in the past year? Yes no
15. Do you ever wake up from sleep short of breath? Yes no
16. Are you on special diet? Yes no
17. Has your medical doctor ever said you have a cancer or tumor? Yes no
18. Do you have any diseases, conditions or problems not listed? Yes no
19. Women: Are you pregnant now? Yes no
    Are you practicing birth control? Yes no
    Do you anticipate becoming pregnant? Yes no

List of Current Medication?_____

To the best of my knowledge, all of the preceding answers are true and correct. If there are any changes in my health, or if my medication changes, I will inform the dentist at the next appointment without fail.

Signature:_____ _____ Date:_____

Printed Name:_____

For office use only:

Date: _____ Signature:_____ Date:_____ Signature:_____

Date:_____ Signature:_____ Date:_____ Signature:_____

## Dental History

1. What is the reason for today's visit?_____
2. How frequently do you see the dentist?_____
3. When was your last dental visit?_____
4. When were your last dental x-rays taken?_____
5. How often do you brush your teeth?_____ Floss?_____ Mouth rinse:_____
6. Do your gums feel swollen or tender?_____ known possible reason:_____
7. Are your teeth sensitive to Cold?____ Sweets?_____ Hot?_____ Pressure?_____
8. Does your mouth have an unpleasant taste or odour?_____ Describe:_____
9. Does your jaw crack or pop when you open widely?_____
10. Do you grind or clench your teeth?_____
11. Have you ever had IV sedation?_____ do you have any history of familiar sedation/ anesthetic complications? Yes No
12. Have you ever had any problems with previous dental treatment?_____

## Elective Treatment

1. Are you interested in ***Cosmetic Dentistry***?_____ Reason or Concern: _____ Comment:_____
2. Are you interested in ***Botox Cosmetic***?_____ Reason or Concern:_____ Comments:_____
3. Do you have crooked or misaligned teeth? _____ Are you interested in ***Invisalign*** (Clear invisible orthodontic)?_____ Reason or Concern:_____

## Important Information/Patient Policy

**Cancellation Policy**

We understand that unforeseen events happen occasionally in everyone's life. In our desire to be effective and fair to all patients, the following policies are in effect:

**48 business hours notice for regular appointment and one week for more than one and half hour appointment is required when rescheduling or canceling appointment.** This will allow us to give the opportunity for another patient needing the appointment. Failure to give us the required notice will incur charges on your account of $40.00 for regular appointment and $100.00 for longer appointment. No shows are charged the same as above.

**Late arrivals**

If you are late, you have to expect that your appointment will be shortened to respect the other patient booked after your appointment. We value your time and ours. Please plan accordingly when you have a scheduled dental appointment.

**Regarding Your Dental Insurance**

As an additional service to our patients in the office, we will submit your insurance claims on your behalf. However, due to the privacy act that was implemented in the province of British Columbia, some insurance companies will not provide insurance information such as breakdown of information and other detailed procedure over the phone. Because of this, it limits our ability to provide you accurate information about procedures and claims that are needed for you. As a plan holder, you must know what benefit you have most importantly if your plan is active and if you have financial maximums.

We as a dental office will make the very most to help you with your claims. Strict cooperation from our patients is paramount in keeping our request to your insurance updated. Please inform the dental office for any estimate or notices you are receiving from your insurance provider.

We will do our best to communicate all your financial responsibilities in the office at the time of your appointment. Any short or non-payment from your insurance due to lapse coverage or plan limit will be your sole responsibility.

**Acknowledgement:**

I have read the above policies and fully understand my responsibilities as a patient.

_____ _____ _____

(Print) Patient Name Signature Date