CAMBIE MARINE GATEWAY DENTAL

WELCOME TO CAMBIE MARINE GATEWAY DENTAL

Please answer the following questions to help us to better care for your dental needs. All information will be confidential and is for our records only.

DR./ MR./ MRS./ MS./ MISS./ MSTR. Last Name________________________________ First Name________________________________

Birth date (M/D/YR) ____________________________________ Male( ) Female( )

Address____City________________________ POSTAL CODE_____________

Phone HM_________________________________WK_______________________________CELL________________________________

EMAIL____ Best way to contact you _______________________________

How did you hear about our office? ____

MEDICAL HISTORY

Name of physician_________________________________ phone____________________________

Women only – are you pregnant? **Y N** due date___________________________________

Do you smoke? (tobacco, marijuana, other) **Y N** How long have you smoked, and how many per day? __________________________

Have you been hospitalized in the past 5 years? **Y N** For what reason? ____

Please circle all of the conditions that you have now or have had in the past

Asthma/Hay Fever	High/Low Blood Pressure	Epilepsy/Seizure Disorder	Stomach Disorders	Thyroid Disease
Cancer	Heart Murmur	Substance Abuse	Psychiatric Disorders	Blood Disorders/Anaemia
Diabetes	Heart Attack/Surgery	Arthritis/Rheumatism	Lung Disease/Tuberculosis	STD's
Sinus Trouble	Artificial Joints/Heart Valves/Pacemaker		Hepatitis/Jaundice/Liver Disease	
AIDS/HIV+	Frequent Alcohol Consumption		Frequent/Severe Headaches	

If you have any disease, condition or problem not mentioned about, please describe ______________________________

Have you ever had an unusual reaction/ allergy to any medication? (i.e.: penicillin, codeine, local anesthetic, sulpha, NSAIDs, etc)

____

Please list medications you are currently taking (prescription and/or non-prescription) _______________________________________

____

Dental History

Name of previous dentist________________________ Date of last dental visit_________________ Purpose of visit_________________

Have you had regular dental visits in the past? **Y N** Are you currently having any dental pain? **Y N**

Have you been treated for periodontal (gum) disease in the past? **Y N** Is there a family history of periodontal (gum) disease? **Y N**

Do your gums bleed when you brush or floss? **Y N** Are you aware of any sores or lumps in your mouth? **Y N**

Do you get popping or clicking sounds from your jaw? **Y N** Are you aware of clenching or grinding your teeth? **Y N**

Have you had surgery/radiation treatment to your head/neck? **Y N** Have you ever had orthodontic treatment (braces)? **Y N**

Have you ever had a bad reaction or abnormal bleeding with past dental procedures? **Y N**

How often do you brush your teeth? ______________________ Manual ☐ Electric ☐ How often do you floss? _____________________

Is there anything about the appearance of your teeth that concerns you? ____

When receiving dental treatment would you consider yourself: Relaxed___ Mildly apprehensive___ Nervous but under control___ Extremely nervous____

What concerns you most about receiving dental treatment?____

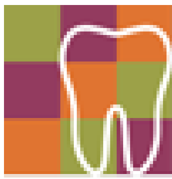
What, if any, is/are your current dental issue(s)?____

Consent to Treatment:

1. I certify that the above information is correct to the best of my knowledge.
2. I authorize the doctor upon consultation and direct consent from the patient/parent/guardian to perform diagnostic procedures, treatment, and medication in the connection with the patient's dental needs.
3. I understand that responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time services are rendered and despite any dental insurance. I am ultimately responsible for any fees withheld by the insurance company.

_______________________________ ___________________________________ Patient ( ) Parent ( ) Guardian ( )

Date Signature



WELCOME TO CAMBIE MARINE GATEWAY DENTAL

Welcome to our clinic. It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. To keep our standard of care to a level which best serves your dental needs, we ask you to please observe the following guidelines:

CANCELLATION POLICY

There are many times when our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the clinic advanced notice of their need to cancel a scheduled appointment, this time can in turn, be allocated to these patients in need of urgent treatment. In this way the clinic can best serve the needs of ALL patients. Bearing these special needs in mind, **the clinic requires a minimum of 2 business days notice if an appointment must be rescheduled or cancelled**. If less than 2 business days notice is given to cancel an appointment, a $100.00 fee per hour will be applied. Please note that insurance companies do not cover fees for broken appointments, therefore payment is the patient's responsibility.

PAYMENT POLICY

The British Columbia Dental Association states that your dentist or certified specialist is obligated to treat you, not your dental plan. Treatment recommendations are based on your dental health needs, which may differ widely from what your plan covers. Base your decision on an informed discussion with our dental team regarding your dental needs as this decision can impact your health and should not be dictated by your dental plan coverage. Unless prior arrangements have been made, payment is due upon completion of treatment. Please note that not all services may be covered by your insurance carrier and every insurance plan has its own unique "quirks" and exceptions. It is the patient's responsibility to cover procedures that are not covered by their insurance plan. We at Cambie Marine Gateway Dental look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

The following section is to be completed by the patient.

I have read the above policies of the Dental Clinic and understand my responsibilities as a patient.

____________ __________________________ ___________________________________

Date *Print Name* *Signature of patient*

I give consent for receiving Email Newsletters that may contain Promos, Info & Marketing Materials **Y N**