FIFTH AVENUE DENTAL

1808 West Fifth Avenue, Vancouver, BC V6J 1P3
Tel: 604 734-8880 Fax: 604 734-2410

Patient Information

Last Name: ________________________________ First Name: ______________________________

Date of Birth: ________/________/__________ Home No: ________________________________
MM DD YR

Cell No: ________________________________

Work No: ________________________________

Email Address: ____

Preferred Contact Method: ☐ Home ☐ Cell ☐ Text ☐ Work ☐ Email

Residence address: ____

City: _____________________________ Prov. _____________ Postal Code: __________________

A parent or guardian will be responsible for decisions on my treatment. ☐ Yes ☐ No
Parent/Guardian: ____

Emergency Contact: __________________________________ Tel. No: __________________

Family Doctor: ______________________________________ Tel. No: __________________

*****How did you hear about us? ____**

Insurance Information - Primary & Secondary

1. Policy Holder's Name: _________________________ Policy Holder's D.O.B: MM / DD / YR
   Insurance Company: __________________________ I.D. Certificate No: ______________________
   Employer: ___________________________________ Group/Policy No: _________________________

2. Policy Holder's Name: _________________________ Policy Holder's D.O.B: MM / DD / YR
   Insurance Company: __________________________ I.D. Certificate No: ______________________
   Employer: ___________________________________ Group/Policy No: _________________________

General Release

By signing, I understand that the information contained in the medical and dental history is important to my treatment. I certify that all of 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.

______________________________________ ______________________________________
Patient or Guardian Signature Date

Dental History

What is the reason for your initial visit with us? ____

When was your last dental xrays? ____

There are 5 reasons why a person resist going to the dentist, choose the one that would apply to you?

☐ Fear ☐ Time ☐ Budget ☐ No sense of urgency ☐ Trust ☐ N/A

Which one of these is the most important to you? ☐ Cosmetic ☐ Function ☐ Comfort ☐ Longevity

Are you happy with the appearance of your teeth? ………………………..…………..…..…. ☐ Yes ☐ No

If no, please explain: ____

Have you had an unfavorable dental experience before? ………………………..………..…..… ☐ Yes ☐ No

How often do you brush per day? ____________, Floss? _____________, Mouth wash? _____________,

Are your teeth sensitive to ☐ Cold ☐ Sweets ☐ Hot ☐ Other? ____________________

Do your gums bleed while brushing or flossing? ……………………………….……..…… ☐ Yes ☐ No

Do you feel any discomfort to any of your teeth? ………………...…………….……… ☐ Yes ☐ No

Have you had periodontal (gum) surgery? …………………………………….………….. ☐ Yes ☐ No

Do you have frequent headaches? ……………………………………………....……. ☐ Yes ☐ No

Have you had a head, neck or jaw injury? ………………………….…….……...…… ☐ Yes ☐ No

Have you had orthodontics treatment (Braces/Invisalign)? …………….…….………… ☐ Yes ☐ No

Medical History (This information will remain confidential.)

Are you presently under the care of a physician? ………………………………………. ☐ Yes ☐ No

Have you recently (within 2 years) been in the hospital or had major operation? ……… ☐ Yes ☐ No

Are you taking any drugs or medication at this time? ………………………………….. ☐ Yes ☐ No

If yes, please list: ____

Have you ever had an adverse effect to: ☐ Penicillin ☐ Codeine ☐ Local anesthetic

Have you ever been warned against using any other medication? ……………………… ☐ Yes ☐ No

If yes, please list: ____

Have you ever taken prolonged medical or non-medical drugs? ……………………….. ☐ Yes ☐ No

If yes, please list: ____

Do you suffer from any allergies (hay fever, latex, etc.)? ………………………………. ☐ Yes ☐ No

If yes, please list: ____

Do you bruise easily or have prolonged bleeding? ………………………………………. ☐ Yes ☐ No

Do you smoke? ……………………………………………………………………….. ☐ Yes ☐ No

If yes, how much per day? ____

Have you ever fainted, had shortness of breath or chest pain? ………………………….. ☐ Yes ☐ No

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

☐ Diabetes	☐ Emphysema	☐ Kidney Disease	☐ Head/Neck Injuries
☐ Jaundice	☐ Leukemia	☐ Liver Disease	☐ Artificial Heart Valve
☐ Anemia	☐ Anorexia	☐ Blood Disorder	☐ Heart Pacemaker
☐ Arthritis	☐ Bulimia	☐ HIV Positive	☐ Heart Rhythm Disorder
☐ Stroke	☐ Bronchitis	☐ Lung Disease	☐ Hepatitis A-B-C
☐ Asthma	☐ Sinus Trouble	☐ Hypertension	☐ High/Low Blood Pressure
☐ Herpes	☐ Glaucoma	☐ Artificial Joints	☐ Venereal Disease
☐ Ulcers	☐ Heart Murmur	☐ Thyroid Disease	☐ Circulation Problems
☐ Cancer	☐ Epilepsy	☐ Tuberculosis	☐ Angina Pectoris
☐ Aids	Additional Comments: ______________________		

Women Only: Are you pregnant? ☐ Yes ☐ No, Due Date: ______________________

Are you nursing? ☐ Yes ☐ No

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Financial Agreement

This agreement is to acknowledge that Fifth Avenue Dental Centre, as a courtesy to its patients, will accept payment from and assist in administering most patients dental insurances. **Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.**

Our staff invests a significant amount of time in confirming and preauthorizing insurance coverage details & treatments to the best of our abilities. However, because there is a large number of insurance companies with various amount of different types of plans which are protected by the *Personal Information Protection Act (PIPA),* we may be restricted to access all information to be fully aware of what is on your plan. With your consent to access the details of your dental plan, we will do what is allowed by your plan to get the information we need to help you. Should your insurance benefits result in less coverage, **you are responsible for your account balance.**

We will, however, give you an approximate estimate of what the total treatment may cost and we will also do our best to estimate what your dental plan will pay for the proposed treatment. We do ask that you pay your portion (deductible and co-payments) at each visit and we further ask that if your dental plan does not pay due to a discrepancy, that **you will pay your account balance within 60 days of notification to avoid an interest charge and/or collection.**

By signing, I have read and understand this statement and I agree to allow Fifth Avenue Dental Centre to access what is limited to them the detail of my dental plan and if my dental plan does not cover all of the costs of my dental treatment, I will pay the balance owing.

______________________________ ____________________________
Patient or Guardian Signature Date

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When you book an appointment, we are reserving time with our doctor, assistant and/or hygienist. We will be sterilizing and preparing your operatory space as well as all the equipment and materials required for your procedure. There are times when patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the clinic enough notice of their need to cancel an appointment, this time can allocated to those patients in need. This way the clinic can best serve the needs of ALL patients.

Cancellation Policy

We require 2 business days' notice for any changes or cancellations to your reserved appointment to avoid a cancellation charge of $100. We DO NOT accept cancellations on our answering machine or email.

Confirmation Policy

We will call, email or text (if applicable) to confirm your reserved appointment 2 weeks prior to the appointment date. **We ask that you reply back to confirm your reserved appointment within 2-3 days** of receiving the confirmation.

We will also give you a courtesy reminder 2 days prior your confirmed appointment.

______________________________ Patient or Guardian Signature

______________________________ Date