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

FIFTH AVENUE DENTAL

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

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

FIFTH AVENUE DENTAL

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

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.

Failure to provide us with 2 business days' notice or failure to show up for your appointment will result in a cancellation/no show fee. Depending on the length of the appointment, a minimum of $75.00 up to $125.00 will be added to the account.

In the event a patient does not "show up" on more than 2-3 occasions, we will provide 3 names of other dentists which may suit your schedule better, at which point our administrative team will be happy to forward the records of that patient to the new office with a letter explaining why the referral is being made.

Please note that insurance companies **DO NOT** cover fees for broken appointments, therefore payment is the patient's responsibility and all future scheduled, or required appointments, will no longer be held or booked respectively, until the assessed fee has been paid.
Exceptions will be made for illness or personal tragedy

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