Welcome to EastVan Dental

NEW PATIENT FORM

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form.

PATIENT INFORMATION

The patient is a/an: ☐ Adult ☐ Child ☐ Adult under Guardianship

Medial Alert: ☐ **Yes** ☐ **No**

Patient Name:

Date of Birth:

Title: ☐ Dr. ☐ Mr. ☐Mrs. ☐ Ms. Sex: ☐Male ☐Female ☐Non-Binary ☐ Prefer not to disclose

Address:

Street Unit City Postal code

Home Phone: Mobile:

Email:

Preferred method of contact? ☐ Phone ☐ Text/SMS ☐ Email

Adult Patient

Occupation: Marital Status: ☐Married ☐Single ☐Divorced ☐Widow

Employer:

Work Phone:

Insurance Information:

Primary Insurance

Policy Holder Name:

Policy Holder Birth Date:

Plan Number:

ID Number:

Secondary Insurance

Policy Holder Name:

Policy Holder Birth Date:

Plan Number:

ID Number:

Whom may we thank for referring you? ☐ Google ☐ Website ☐ Newspaper ☐ Patient ☐ Other

EMERGENCY CONTACT

Contact Person Name:

Phone Number:

Relationship to Patient:

DENTAL HISTORY

(Please **CIRCLE** YES/NO to each question. If you're unsure how to answer, please consult our staff!)

Is there a dental problem you would like to be treated for immediately? ☐ Yes ☐ No

Do you have dental anxiety? ☐ Yes ☐ No

If YES, please explain:

Reason for today's visit?

Date of your last dental visit? / Reason for Visit.

1. Are you having regular dental visits? ☐ Yes ☐ No
2. Have you ever had any of the following? ☐ Yes ☐ No
   Periodontal Treatment (treatment of gums)?
   Orthodontic Treatment (to straighten or realign teeth?)
   Oral Surgery (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)
3. Do you feel you have bad breath? ☐ Yes ☐ No
   How often do you brush your teeth? _____ times / day
4. Do you use dental floss, proxabrush, stimudents or any other interproximal tools? ☐ Yes ☐ No
5. Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums? ☐ Yes ☐ No
6. Are any of your teeth sensitive to heat, cold, sweets or pressure? ☐ Yes ☐ No
7. Have you ever experienced any jaw joint problems (TMJ)? ☐ Yes ☐ No
8. Do you have any of the following habits?
   Clenching or grinding your teeth while awake or asleep? ☐ Yes ☐ No
   Biting your cheeks or lips? ☐ Yes ☐ No
   Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? ☐ Yes ☐ No

MEDICAL HISTORY

1. Are you being treated for any medical condition at present or within the past year? ☐ Yes ☐ No
2. If yes please explain.
3. Has there been any changes in your general health in the past year? ☐ Yes ☐ No
4. List any **PRESCRIPTION** or **NON-PRESCRIPTION** drugs you are taking or have recently taken (including birth control pills):

5. Have you ever taken any osteoporosis medications? Zometa, Aredia/Fosamax/Actonel ect.
   ☐ Yes ☐ No
6. Do you need to premedicate with antibiotics prior to dental visits? ☐ Yes ☐ No
7. Have you ever had any adverse or unusual reaction to any medications or injections? (e.g. penicillin, or other antibiotics, aspirin, codeine, local anesthetic ("dental freezing")? ☐ Yes ☐ No
   If YES, please explain:

8. Have you ever been advised against taking any specific type of medication? ☐ Yes ☐ No
9. Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal allergies)?
   ☐ Yes ☐ No
   If YES, please explain:

10. Have you ever fainted during dental or medical treatment? ☐ Yes ☐ No
11. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders?
    ☐ Yes ☐ No
    If YES, please explain:

12. Please indicate which of the following medical conditions you presently have, or ever had:
    (Please circle all that apply and elaborate below)

Asthma ☐	Epilepsy or Seizures ☐	Tuberculosis ☐
Glandular Disorders ☐	Arthritis ☐	Hepatitis ☐
Diabetes ☐	Organ Transplant ☐	Stomach/Intestinal Problems ☐
Lung Disease ☐	Medical Implant ☐	Thyroid Disease ☐
Ulcers ☐	Kidney Disease ☐	Mental Disorder ☐
Sleep Apnea ☐	Liver Disease ☐	Blood Disorders ☐
Cancer ☐	Heart Issues ☐	High Blood Pressure ☐
Stroke ☐	Lung Disease ☐	Low Blood Pressure ☐
HIV/AIDS ☐	Hives/ Skin Rash ☐	Hay Fever ☐
Osteoporosis ☐	Rheumatic Fever ☐	Venereal Disease ☐

Others:

13. WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No

If YES, when is your due date? _____

Are you breastfeeding? ☐ Yes ☐ No

14. Do you smoke or vape? ☐ Yes ☐ No
15. Do you have any conditions, diseases or problems not listed/ asked about above that you think the doctor should know of? ☐ Yes ☐ No

If YES, please explain:

To the bet of my knowledge, all of the proceeding answers and information provided are true and correct.

If I ever have any change in my health, I will inform the doctor at the next appointment without fail

Cancellation of appointments

I agree to keep all scheduled appointments unless I notify the office at least 48 hours prior to the appointment. I understand that failure to keep a scheduled appointment may result in a missed appointment fee of $75 per hour scheduled. If we are able to fill your appointment spot with less notice, we will not charge you.

Signature:

Consent:

I authorize the Doctor and staff to use x-rays, models, and photos for a thorough diagnosis. Once diagnosed, I authorize treatment agreed upon by me. I agree to the use of necessary medication, understanding the associated risks. I consent to sharing photos and images with other patients, potential patients and doctors for treatment and educational purposes, with confidentiality maintained.

Financial Information:

As a courtesy, this office will help prepare and submit your insurance forms, however I understand that any fees not covered by insurance are my final responsibility. By signing this form, I authorize this office to

submit insurance claims and to contact my insurance company on my behalf. In consideration for the professional services rendered to me or at my request, I agree to pay for all services regardless of insurance coverage.

I understand that any fee estimate provided by this office for my dental care is only extended for a period of ninety (90) days from the date of the patient examination.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. A service charge of 18% per year will be charged to my account on any unpaid balance not paid the day of service unless previously written financial arrangements are made. I understand that payment plans are available to assist with payment. I understand that in order to be approved for any payment plan options that a credit report may be run. By signing this form, I authorize a credit check to be administered if I am asking for credit to be extended to me.

I understand that in the event that I default in the payment of fees due to the Doctor, I will be responsible for all expenses incurred by the Doctor including, but not limited to attorney fees, collection expenses, discretionary costs and court costs associated with collecting outstanding fees. I also understand that negative payment information may be reported to credit agencies

Insurance Information:

I understand that I have certain rights to privacy regarding my protected health information. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g., my insurance company); the day-to-day healthcare operations of your practice. I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under insurance. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care options, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.
I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature: