VISTA LANDING DENTAL CLINIC

CHART - NEW PATIENT

Name _____
(First / Middle / Last)

Birth Date _____
(DD/MM/YY)

Sex ☐ Male ☐ Female ☐ Non-Binary

Marital Status ☐ Single ☐ Married ☐ Other

Address _____
City _____ Province _____ Postal Code _____

Phone # Cell Phone _____ Home Phone _____
E-MAIL _____

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

MEDICAL HISTORY

Do you have any allergies? ☐ Yes ☐ No
If Yes, please specify (e.g. name of drugs, metals, latex, local anesthetic)
_____
_____

List all medications (prescription and non-prescription) including vitamins, that you are taking
_____
_____
_____

Have you been admitted to a hospital or needed emergency care during the past 2 years?
☐ Yes ☐ No If Yes, please explain:
_____

Do you have any of the following medical conditions (Please check ONLY the ones that apply)

☐ artificial joints in the past two years	☐ head or neck injuries
☐ asthma	☐ hepatitis (type ___)
☐ blood pressure issues (high/low)	☐ herpes / human papillomavirus (HPV)
☐ blood thinners	☐ hormone deficiency
☐ cancer	☐ immunosuppressive medication
☐ diabetes (HbA1c = ___)	☐ infective endocarditis
☐ epilepsy, convulsions (seizures)	☐ kidney disease
☐ heart disease, heart attack, or cardiac stent	☐ mental disorders
☐ high cholesterol or taking statin drugs	☐ multiple sclerosis
☐ liver disease	☐ neurologic disorders (ADHD, prion disease)
☐ radiation therapy	☐ osteoporosis/osteopenia (bisphosphonates)
☐ thyroid, parathyroid disease	☐ pacemaker or implantable defibrillator
	☐ psychiatric issues
☐ AIDS / HIV	☐ rheumatic or scarlet fever
☐ anemia or other blood disorder	☐ sinus issues
☐ antidepressant medication	☐ stomach or duodenal ulcer
☐ arthritis	☐ stroke
☐ artificial heart valve, repaired heart defect	☐ tuberculosis, measles, chicken pox
☐ autoimmune disease	☐ tumor, abnormal growth
☐ bleeding that is prolonged (INR > 3.5)	☐ ulcers
☐ breathing issues (sleep apnea, snoring)	☐ viral infections and cold sores
☐ digestive disorders (celiac disease, reflux)	
☐ dizziness	☐ diarrhea (persistent)
☐ emphysema, shortness of breath	☐ fever, cough, difficulty breathing
☐ epilepsy, convulsions (seizures)	☐ recent exposure to infectious disease
☐ fainting	☐ recent travel history
☐ glaucoma	☐ undiagnosed rash or lesion on skin

Do you have any other health issues or conditions that we should be aware of? ☐ Yes ☐ No

If yes, please list

_____

_____

_____

DENTAL HISTORY

Date of most recent dental exam _____
Date of most cleaning/x-rays _____

What is/are your immediate concern/s?

_____
_____
_____

Do you have any of the following dental conditions

- ☐ Are any of your teeth sensitive to hot, cold, biting, sweets?
- ☐ Are you fearful of dental treatment
- ☐ Are your teeth becoming more crooked, crowded, or overlapped?
- ☐ Are your teeth developing spaces or becoming more loose?
- ☐ Did you ever have braces, orthodontic treatment or had your bite adjusted?
- ☐ Do you avoid brushing any part of your mouth?
- ☐ Do you avoid or have difficulty chewing hard foods
- ☐ Do you chew ice, bite your nails, use your teeth to hold objects
- ☐ Do you clench your teeth in the daytime or make them sore?
- ☐ Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth
- ☐ Do you have any problems with sleep, or wake up with a headache?
- ☐ Do you have grooves or notches on your teeth near the gum line?
- ☐ Do you have problems with your jaw joint? (pain, limited opening, locking, popping)?
- ☐ Do you wear or have you ever worn a bite appliance?
- ☐ Do your gums bleed or are they painful when brushing or flossing?
- ☐ Does the amount of saliva in your mouth seem too little?
- ☐ Have you ever been treated for gum disease
- ☐ Have you ever experienced a burning sensation in your mouth?
- ☐ Have you ever experienced gum recession
- ☐ Have you ever had an unfavorable dental experience?
- ☐ Have you ever had complications from past dental treatment?
- ☐ Have you ever had trouble getting numb or had any reactions to local anesthetic?
- ☐ Have you ever noticed an unpleasant taste or odor in your mouth?
- ☐ Have you had any teeth removed?
- ☐ Have your teeth changed in the last 5 years, become shorter, thinner or worn?
- ☐ Is there anything about the appearance of your teeth that you would like to change?

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I consent to the dental procedures agreed to be necessary and advisable for myself or my child including the use of local anesthetic, or other drugs as indicated.

I authorize the dentist to release any information including X-Rays, diagnostic and treatment records for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I authorize my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balances on my account.

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the dentist. This authorization shall continue in effect until the undersigned revokes the same.

I hereby assign my benefits, payable from claims submitted electronically to the dentist, and authorize payment directly to him/her.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I consent to communicating with, and receiving information from Vista Landing Dental Clinic via phone, email and text messaging.

_____	_____	_____
NAME (PLEASE PRINT)	Signature (Patient/Parent/Guardian)	DATE