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WELCOME TO OUR DENTAL OFFICE. Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain within this office. Our reception staff is available to assist you with the completion of this form. **Please Print**

REGISTRATION INFORMATION

Name _____ Date of Birth (dd/mm/yy) _____ Sex _____

Address _____ Postal Code _____

Home Phone (____) _____ E-mail/cell _____ Work Ph. _____

Employer/Occupation _____ Can we call you at work? yes no

Family Physician _____ Phone (____) _____

Emergency Contact/Spouse/Parents _____ Phone (____) _____

Referrals are important to us. Who may we thank for referring you to our office? _____

PRIMARY DENTAL INSURANCE

Subscriber's name _____

Employer _____

Ins. Co. _____ D.O.B. _____

Policy #/Cert. # _____ Dep. # _____

S.I.N. _____ Finance Limit _____

Deductable _____ Ins. Year End _____

% coverage: Basic ___ C&B ___ Denture ___ Ortho ___

Recall frequency _____

SECONDARY DENTAL INSURANCE

Subscriber's name _____

Employer _____

Ins. Co. _____ D.O.B. _____

Policy #/Cert. # _____ Dep. # _____

S.I.N. _____ Finance Limit _____

Deductable _____ Ins. Year End _____

% coverage: Basic ___ C&B ___ Denture ___ Ortho ___

Recall frequency _____

DENTAL INFORMATION

Is there a dental problem you would like treated immediately? yes no. If yes, please specify _____

Would you like your records/xrays transferred from your last dentist? yes no

If so, who do we call _____

1. Have you been seeing a dentist regularly? yes no Date of last dental visit: _____

2. Do your gums bleed when brushing or eating? yes no Date of last dental cleaning: _____

3. Are any of your teeth sensitive to heat, cold, sweets or pressure? yes no

4. Have you been advised to take antibiotics before a dental appointment? yes no

5. Do you have problems with your jaw joint (pain, clicking, locking)? yes no

6. Do you clench or grind your teeth in the day/night? yes no

7. Are you unhappy with the appearance of your teeth? yes no What would you like to see changed?

8. Have you ever had an upsetting experience at a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? yes no

DENTAL INFORMATION

1. Have you had any serious illness in the past 5 years which required medical treatment? yes no

If yes, please explain _____

2. Are you currently under a physician's care, or taking any medication? yes no

Please specify _____

3. Do you have any allergies or sensitivities to any drugs such as penicillin, novocaine, aspirin or codeine? yes no

Please specify _____

4. Have you ever been advised against taking any specific medication? yes no

5. Do you bleed excessively after a cut, wound or surgery? yes no

6. Indicate which of the following you presently have or ever had

A.I.D.S.	<input type="checkbox"/> yes <input type="checkbox"/> no	Head/neck injuries	<input type="checkbox"/> yes <input type="checkbox"/> no	Malignant Hyperthermia	<input type="checkbox"/> yes <input type="checkbox"/> no
Allergies	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart disease or attack	<input type="checkbox"/> yes <input type="checkbox"/> no	Mental/nervous disorder	<input type="checkbox"/> yes <input type="checkbox"/> no
Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart murmur	<input type="checkbox"/> yes <input type="checkbox"/> no	Mitral valve prolapse	<input type="checkbox"/> yes <input type="checkbox"/> no
Angina	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no	Organ transplant/medical implant	
Arthritis/rheumatism	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart rhythm disorder	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
Artificial heart valve	<input type="checkbox"/> yes <input type="checkbox"/> no	Heart surgery	<input type="checkbox"/> yes <input type="checkbox"/> no	Psychiatric treatment	<input type="checkbox"/> yes <input type="checkbox"/> no
Artificial joints (hip, knee)	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis A	<input type="checkbox"/> yes <input type="checkbox"/> no	Radiation treatment/chemotherapy	
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis B	<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
Blood disorders	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis C	<input type="checkbox"/> yes <input type="checkbox"/> no	Rheumatic Fever	<input type="checkbox"/> yes <input type="checkbox"/> no
Bronchitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Hepatitis _____	<input type="checkbox"/> yes <input type="checkbox"/> no	Sickle cell disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	High/Low blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	Sinus trouble	<input type="checkbox"/> yes <input type="checkbox"/> no
Circulation problems	<input type="checkbox"/> yes <input type="checkbox"/> no	H.I.V.	<input type="checkbox"/> yes <input type="checkbox"/> no	Stomach/intestinal problems	<input type="checkbox"/> yes <input type="checkbox"/> no
Congenital heart lesions	<input type="checkbox"/> yes <input type="checkbox"/> no	Hodgkin's disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no
Cortisone/steriod	<input type="checkbox"/> yes <input type="checkbox"/> no	Hyper (Hypo) Glycemia	<input type="checkbox"/> yes <input type="checkbox"/> no	Thyroid disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Hypertension	<input type="checkbox"/> yes <input type="checkbox"/> no	Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no
Emphysema	<input type="checkbox"/> yes <input type="checkbox"/> no	Jaundice	<input type="checkbox"/> yes <input type="checkbox"/> no	Ulcers	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy or seizures	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Venereal Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Fainting or dizzy spells	<input type="checkbox"/> yes <input type="checkbox"/> no	Liver disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Other _____	
Glandular disorders	<input type="checkbox"/> yes <input type="checkbox"/> no	Lung disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Other _____	
Glaucoma	<input type="checkbox"/> yes <input type="checkbox"/> no				

7. Women only: Are you pregnant or suspect you may be? yes no

If yes, what is the expected delivery date? _____

OFFICE POLICIES

We respect that your time is valuable and we request that you respect our time as well. If you book an appointment please attend it. We require at least 24 hours notice for changes. A fee will be charged for missed, unrescheduled appointments.

For patients with dental insurance

Claims for dental service will be sent to Dental Insurance Companies, providing coverage is in effect at time of dental services. Payment of patient's percentage is due at the time of the appointment. It is your, the patient's, responsibility to know your insurance financial and procedure limits. We do not accept responsibility for amounts not covered by individual insurance policies.

Interest will be charged on overdue accounts (60 days) at 2% per month (24% per annum) _____ (initials please)

For patients without dental insurance

Payment is due at time service is provided.

Signature _____ Date _____