WHISTLER DENTAL
IN THE VILLAGE

WELCOME TO WHISTLER DENTAL

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH / / M / D / Y	SEX M ☐ F
HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED CONTACT HOME ☐ WORK ☐ CELL ☐	
MAILING ADDRESS	CITY	PROV/STATE	POSTAL/ZIP CODE	
EMAIL ADDRESS			TODAY'S DATE	

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME HOME # CELL # WORK #

HOW DID YOU HEAR ABOUT OUR OFFICE? Referred by other person: _____

Other: _____

DO YOU HAVE DENTAL INSURANCE COVERAGE?

If yes, please provide the receptionist with your benefit information BC residents ONLY).

Primary Coverage YES ☐ NO ☐ Secondary Coverage YES ☐ NO ☐

Please answer the following questions to help us better care for your dental needs. All informations will be confidential and is for our records only.

GENERAL INFORMATION

Full time Resident: _____ Seasonal Resident (living/working in Whistler for a period of time): _____

Part time Resident (between Whistler and another location): _____ Visitor/Tourist: _____ Working Visa: _____

If seasonal or working visa Resident, how long do you expect to be living in Whistler? _____

DENTAL INFORMATION

Name of previous dentist: _____ Last dental visit: _____ Reason: _____

I routinely see my dentist every: 3 mo. ☐ 4 mo. ☐ 6mo. ☐ 12 mo. ☐ Not Routinely ☐

ARE YOU CURRENTLY EXPERIENCING DENTAL PAIN? YES ☐ NO ☐ Explain: _____

_____

WHAT IS YOUR IMMEDIATE CONCERN? _____

_____

When you receive dental treatment would you consider yourself: Relaxed ☐ Mildly Apprehensive ☐ Nervous ☐ Extremely Nervous ☐

Have you been treated for periodontal (gum) disease in the past? Y ☐ N ☐

Is there a family history of gum disease? Y ☐ N ☐ Do your gums bleed when you brush or floss? Y ☐ N ☐

Are you aware of any lumps or sores in your mouth? Y ☐ N ☐ Are you interested in straightening your teeth? Y ☐ N ☐

Have you ever had orthodontic treatment (braces or Invisalign)? Y ☐ N ☐

Do you wish your teeth could be whiter? Y ☐ N ☐ Do you like the shape of your teeth? Y ☐ N ☐

Do you have sensitive, broken, worn, loose or missing teeth? Y ☐ N ☐ Do you feel your teeth shift or move? Y ☐ N ☐

Do you have spaces, chip or uneven edges that bother you? Y ☐ N ☐

Do you ever feel uncomfortable or self concious about the appearance of your teeth? Y ☐ N ☐

On a scale from 1 - 10, 10 being very important, how important is it to keep your natural teeth? _____

If you could change anything about your smile what would it be? _____

BITE, JAW JOINT AND SLEEP HISTORY

Please check any of the following that apply to you.

EAR

☐ 1. Ear pain without infection
☐ 2. Decreased hearing
☐ 3. Clogged, itchy or stuffy
☐ 4. Ringing / buzzing
☐ 5. Dizziness
☐ 6. Balance problems

THROAT

☐ 1. Swallowing difficulties
☐ 2. Feeling of foreign object in throat
☐ 3. Sore throat without infection
☐ 4. Voice changes
☐ 5. Laryngitis
☐ 6. Frequent coughing or clearing

EYES

☐ 1. Bloodshot eyes
☐ 2. Pain in / around eyes
☐ 3. Sensitive to light
☐ 4. Tearing of eyes
☐ 5. Blurred vision
☐ 6. Pressure behind eyes

MOUTH

☐ 1. Abnormal opening
☐ 2. Limited opening
☐ 3. Bad bite
☐ 4. Missing teeth
☐ 5. Excessive mouth breathing
☐ 6. Clench or grind teeth
☐ 7. Mouth discomfort
☐ 8. Inability to find “bite”

HEAD/FACE

☐ 1. Forehead headaches
☐ 2. Temporal headaches
☐ 3. Tension headaches
☐ 4. Migraine headaches
☐ 5. Sinus headaches
☐ 6. Back of head headaches
☐ 7. Hair scalp tender to touch

NECK

☐ 1. Lack of mobility
☐ 2. Stiffness
☐ 3. Neck pain
☐ 4. Tired/sore neck muscles
☐ 5. Shoulder pain
☐ 6. Back pain: middle, lower
☐ 7. Arm/finger pain/numbness

JAW

☐ 1. Jaw pain, joint pain
☐ 2. Jaw locks open / shut
☐ 3. Grating sound in jaw joint
☐ 4. Pain in cheek muscles
☐ 5. Uncontrollable jaw movements
☐ 6. Deviates to one side on opening or closing

NASAL

☐ 1. Sinus pain
☐ 2. Sinus problems
☐ 3. Post nasal drainage
☐ 4. Allergies

Please check any of the following that apply to you.	Internal Score
Have you ever been told you stop breathing while asleep?	8
Have you ever fallen asleep or nodded off while driving?	6
Have you ever woken up suddenly with gasping or with your heart racing?	6
Do you feel excessively sleepy during the day?	4
Do you snore, or have you ever been told that you snore?	4
Have you had weight gain and found it difficult to lose weight?	2
Have you taken medications for or been diagnosed with high blood pressure?	2
Do you kick or jerk your legs while sleeping?	3
Do you feel burning, tingling or crawling sensations in your legs when you wake up?	3
Do you wake up with headaches during the night or in the morning?	3
Do you have trouble falling asleep?	4
Do you have trouble staying asleep once you fall asleep?	4

Low = 0-7 Moderate = 8 - 11 High = 12 -15 Severe = 16+ **Score and risk factor:** _____

MEDICAL HISTORY

Name of Physician: _____ Phone: _____

Date of last physical: _____

Do you have any allergies or adverse reaction to any medications? (i. e. penicilin, codeine, local anesthetic, sulpha, latex)

YES ☐ NO ☐ If yes, please list: _____

Please check all of the conditions you have.

- ☐ Abnormal bleeding or bruising
- ☐ Acid Reflex / Digestive Disorders
- ☐ AIDS or HIV
- ☐ Anxiety attacks
- ☐ Arthritis / Rheumatism / Lupus
- ☐ Asthma / Hay Fever
- ☐ Broken jaw / TMJ injury
- ☐ Cancer / Chemotherapy / Radiation
- ☐ CPAP user
- ☐ Diabetes
- ☐ Epilepsy / Seizure Disorder
- ☐ Glaucoma
- ☐ Gag Easily
- ☐ Heart Attack / Surgery
- ☐ Heart Murmur / Heart Condition
- ☐ Hepatitis A, B, C
- ☐ High or low blood pressure
- ☐ Sunstance Abuse
- ☐ Hyper (hypo) glycemia
- ☐ Liver Disease
- ☐ Lung disease / Tuberculosis
- ☐ Menopause
- ☐ Mental or Nervous disorders
- ☐ Mouth Breather
- ☐ Pacemaker / Artificial Joints
- ☐ Pregnant
- ☐ Sleep Apnea / Sleep Disorder
- ☐ Snore when sleeping
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other _____

Describe any current medical treatment , impending surgery, gentic/development delay or other treatment that may possibly affect your dental treatment (i. e. Botox, Collagen injections).

List all medications, supplements, and or vitamins that you are currently taking.

Drug	Purpose	Drug	Purpose

IMPORTANT!
WE WOULD LIKE TO PROVIDE THE BEST TREATMENT OPTIONS AVAILABLE TO YOU BASED ON CURRENT AND ACCURATE INFORMATION. PLEASE ADVISE US OF ANY CHANGES IN MEDICATIONS OR TREATMENTS YOU HAVE UNDERGONE SINCE YOUR LAST VISIT.

APPOINTMENT CHANGE POLICY & PAYMENT

** **We have reserved your appointment time for you, if you need to alter your appointment, please provide our office with a minimum of 48 hours advance notice during business hours to avoid a cancellation fee.**

** I hereby authorize my insurance benfits to be paid directly to the dentist. I understand that I am financially responsible for any balance not paid by my insurance compnay which will be **taken from my credit card directly.**
** I authorize the dentist to release information for any claim to my insurance company.

** I certify that I have read the contents of this form and understand what is expected of me. I have completed this form accurately to the best of my knowledge.

PATIENT / GUARDIAN SIGNATURE **DATE**

_____ _____

WHISTLER DENTAL INSURANCE INFORMATION

As a courtesy and convenience to you, Whistler Dental accepts dental insurance plans upon confirmation of your coverage and allowable treatment. Based on this information, we are able to provide you with estimates of treatment required to the best of our knowledge. If we cannot get confirmtion of coverage and allowable treatment BEFORE your appointment, patients are required to pay the FULL amount at the time of treatment.

Your dental policy is a contract between you, your employer and your insurance company. Should your coverage terminate or change in any way, we can only be notified of the by YOU, the patient. If treatment is not paid by your dental plan, it is the SOLE responsibility of you, the patient, to cover ALL costs. If your insurance company denies treatment, Whistler Dental will not resubmit insurance claims on your behaf and will then become your responsibiliy.

We will try our best to keep track of your hygiene frequency but it is ultimately your responsibility to know your recare/hygiene coverage intervals. Whistler Dental will not be responsibe if treatment is not covered due to “early cleaning” appointments.

In order for us to accept your insurnce plan, we will require a valid credit card to remain on file for any treatment that is not covered by your insurance company.

We bill all treatment done on the day the service is rendered. If we have not received payment from your insurance company plan within 30 days of services rendered, then the claim becomes your responsibilty. Any portion of any claim submitted to you insurance company that is not paid in a timely manner, will then become your responsibility and will be charged to your credit card automatically.

If you require any assistance with your insurance, please speak with one of out staff; we would be more than happy to help.

I have read and understand the above and agree with the terms and conditions.

Credit card information: Visa ___ Mastercard ___
Name on Card: _____
Card Number: _____
Expiry Date: _____ 3 Digit Code: _____

**Note all credit card information is kept confidential

Patient Name (please print): _____
Signature _____ Date: _____
Patient ( ) Parent ( ) Guardian ( )