Kelowna Family Dental
Taking Care of your Smile!

**Patient Information & Health History**

**Name:** Surname:_____ First:_____ Middle Initial:____

**Preferred Name:** _____ **Gender:** M / F / O **Birthdate:** _____

**Address:**_____ **City:** _____ **Postal Code:**_____

**Home Phone:**_____ **Cell Phone:**_____ **Work Phone:** _____

**Email:**_____

**Occupation:**_____ **Employer:** _____

**Emergency Contact:** _____ **Phone:**_____

**Drivers License #:**_____

**How did you hear about our office:**_____
If it is someone we know, we would love to thank them so please provide their name.

**Dental Insurance:** □ Yes □ No

**Insurance Company:** _____ Group/Policy #: _____Certificate/ID#:_____

Policy Holder:_____ Policy Holder Birthdate: _____

Policy Holder Employer: _____ Policy Holder Address (if different): _____

Coverage: Basic:_____% Major: _____% Ortho: _____% Yearly Maximum: _____

**Insurance Company:** _____ Group/Policy #: _____Certificate/ID#:_____

Policy Holder:_____ Policy Holder Birthdate: _____

Policy Holder Employer: _____ Policy Holder Address (if different): _____

Coverage: Basic:_____% Major: _____% Ortho: _____% Yearly Maximum: _____

**Medical History**

**Physician:** _____ **Phone #:** _____

**Are you allergic to anything?** □ Yes □ No If yes, please list:_____

**Have you been advised to take pre-medication antibiotics prior to dental treatment** □ Yes □ No

**Do you have or have you ever had any of the following:**

| | | | |
|---|---|---|---|
| Rheumatic Fever | □ Yes □ No | Congenital Heart Defect/Murmur | □ Yes □ No |
| Circulatory Problems | □ Yes □ No | Hepatitis/Jaundice/Liver Disease | □ Yes □ No |
| Kidney Disorder | □ Yes □ No | High Blood Pressure | □ Yes □ No |
| Asthma/Lung Problems | □ Yes □ No | Low Blood Pressure | □ Yes □ No |
| Sinus Problems | □ Yes □ No | Nervous Disorders/Seizures/Fainting | □ Yes □ No |
| Infectious Disease | □ Yes □ No | Bleeding Disorder | □ Yes □ No |
| Arthritis | □ Yes □ No | Diabetes | □ Yes □ No |
| Headaches | □ Yes □ No | Artificial Joints or Valves | □ Yes □ No |
| Heart Disease | □ Yes □ No | Cancer/Chemotherapy/Radiation | □ Yes □ No |
| Contact Lenses | □ Yes □ No | Currently Pregnant | □ Yes □ No |

Please see next page

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**Are you currently being treated for any illnesses?** □ Yes □ No

If yes, please provide details: _____

**Are you currently taking any medications** □ Yes □ No List:_____

_____

**Do you smoke/vape/cannabis** □ Yes □ No **Do you grind/clench your teeth** □ Yes □ No

**Is there any additional information related to your health that has not been addressed above?**

_____

**Dental History**

**Main Dental Concern:** _____

**Previous Dentist:** _____ **Date of Last Exam:** _____

| | |
|---|---|
| Do your gums bleed when brushing/flossing | □ Yes □ No |
| Are your teeth sensitive to hot/cold/sweets | □ Yes □ No |
| Do you have any tooth pain | □ Yes □ No |
| Do you have any sores/lumps in your mouth | □ Yes □ No |
| Do you have any jaw problems | □ Yes □ No |
| Do you ever notice an unpleasant taste or bad breath | □ Yes □ No |
| Have you had difficult extractions before | □ Yes □ No |
| Have you had prolonged bleeding after extractions | □ Yes □ No |
| Do you snore | □ Yes □ No |
| Do you have sleep apnea | □ Yes □ No |
| Do you want straighter teeth | □ Yes □ No |

**How often do you: brush your teeth** _____ **floss your teeth** _____

**Do you have any other dental concerns or history not addressed above?** _____

_____

**Is there anything about your mouth or smile that you wish you could change?** _____

_____

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this, we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

**Signature of patient or parent/guardian**_____ **Date:**_____

I understand and acknowledge that I am solely and ultimately responsible for my account, and that if I have dental insurance, and although this office may submit claim forms on my behalf, I am responsible for any unpaid claims, or portions thereof.

**Signature of patient or parent/guardian**_____ **Date:**_____

We will contact you to confirm your appointments. We require 2 business days notice to reschedule your appointment.