Whistler Dental

WELCOME TO WHISTLER DENTAL

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

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 our receptionist with your benefits information (BC Residents ONLY).

Primary Coverage ☐ Yes ☐ No Secondary Coverage ☐ Yes ☐ No

Please answer the following questions to help us to better care for your dental needs. All information 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 stay in Whistler? _____

If this is an emergency visit, would you like more information about becoming a regular patient of Whistler Dental: Yes No

DENTAL INFORMATION

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

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

ARE YOU CURRENTLY EXPERIENCING DENTAL PAIN? Yes No Explain: _____

WHAT IS YOUR IMMEDIATE CONCERN? _____

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

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

When receiving dental treatment would you consider yourself: Relaxed ___ Mildly apprehensive ____ Nervous ____ Extremely nervous ___

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, chips, or uneven edges that bother you? Y N

Have you ever felt uncomfortable or self conscious 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? _____

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

MEDICAL HISTORY

Name Of Physician/: _____ Phone: _____

Date of Last Physical: _____

Do you have any allergies or adverse reaction to any medications? (I.e. penicillin, codeine, local anesthetic, sulpha, latex) Y N

If yes please list: _____

Please check all of the conditions that you have.

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

Describe any current medical treatment, impending surgery, genetic /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

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

DENTAL BENEFITS / PAYMENT AND APPOINTMENT CHANGE POLICY

** 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 confirmation of coverage and allowable treatment, patients are required to pay the FULL amount at the time of service.

** 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 this 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 behalf and will then become your responsibility.

** In order for us to accept your insurance 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 plan within 30 days of services rendered, then this claim becomes your responsibility. Any portion of any claim submitted to your insurance company that is not paid in a timely manner, will become your responsibly and will be charged to your credit card automatically. Secondary insurance claims are the responsibility of the patient. If you require any assistants with your insurance please speak with one of our staff; we would be more than happy to help.

** If you need to change or alter your appointment, please provide our office with a minimum of 48 hrs advance notice during business hours.

** I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release information for any claim. I certify that I have read the contents of this form, filled in completely and accurately to the best of my knowledge. I understand the change of appointment policy.

PATIENT / GUARDIAN SIGNATURE: **DATE:**

BITE, JAW JOINT AND SLEEP HISTORY

Please check any of the following that apply to you:

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

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

JAW

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

NASAL

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

EYES

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

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

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”

	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: _____

CHILDREN'S BITE, JAW JOINT AND SLEEP HISTORY

Whistler Dental is proud to screen all children for proper craniofacial growth and development. Please check anything that applies to your child.

- ☐ Morning headaches
- ☐ Persistent runny noise
- ☐ Sucks thumb
- ☐ Uses Soother
- ☐ Tonsils/ Adenoids remain
- ☐ Day time sleepiness
- ☐ Overweight
- ☐ Choking or gasping for air while sleeping
- ☐ Mood instability/ aggressiveness/ anxiety
- ☐ Difficulty waking up in morning
- ☐ Lips rest apart
- ☐ Teeth crowding
- ☐ Mouth breather
- ☐ Soft diet
- ☐ Under weight
- ☐ Poor appetite
- ☐ Night terrors
- ☐ Bed wetting
- ☐ Falls asleep easily in car or school
- ☐ Snores
- ☐ Grinds teeth
- ☐ Dark circles under eyes
- ☐ ADHD symptoms
- ☐ Troubles paying attention in school
- ☐ Forward head posture
- ☐ CPAP user
- ☐ Premature birth
- ☐ Habit of biting objects
- ☐ Breast fed
- ☐ Bottle fed
- ☐ Other _____