Welcome and thank you for choosing VSDC

We are committed to providing our patients with the highest standards of healthcare.

To help us meet all of your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Last Name _____ First Name _____ Gender _____ Date of Birth _____

Address _____ City _____ Province _____ Postal Code _____

Home Phone _____ Cell Phone _____ E-mail _____

May we contact you at your workplace Yes ❒ No ❒

May we contact you on your cellphone Yes ❒ No ❒ If yes: Text ❒ Call ❒

May we contact you by email Yes ❒ No ❒

CASL consent I consent to communicating with this dental office and receiving important information from this office by email, text messaging or social media. This office is committed to never sending spam email and will always take all reasonable precautions to protect my electronic information.

X Signature _____

Health Card Number _____ Driver's License _____

Patient's Employer _____ Work Phone _____ Ext. _____

If Student, Name of University/College _____ City _____

Person to contact in case of emergency _____ Phone _____

Nearest Relative not living with you _____ Phone _____

Information if patient is a minor

Mother's Name _____ Address (if different) _____

City _____ Postal Code _____ Home Phone _____

Father's Name _____ Address (if different) _____

City _____ Postal Code _____ Home Phone _____

Insurance Information ☐ ***Yes*** ☐ ***No***

Name of Insured _____ Relationship _____

Birthdate _____ Name of Employer _____

Insurance Company _____ Policy _____ I.D. # _____

Do You Have Any Additional Insurance? ☐ ***Yes*** ☐ ***No*** ***If yes, complete the following***

Name of Insured _____ Relationship _____

Birthdate _____ Name of Employer _____

Insurance Company _____ Policy _____ I.D. # _____

HOW DID YOU HEAR ABOUT US? _____

Patient Medical History

Family Doctor's Name:_____ Office Phone #_____

yes no

❑ ❑ 1. Are you being treated for a medical condition presently or in the last year? If yes, what:
_____

❑ ❑ 2. Have you ever been hospitalized for any surgical operation or serious illness?
If yes, please explain _____
_____

❑ ❑ 3. Have you had any eye surgery in the last 3 months?

❑ ❑ 4. Are you taking any medication(s) including non-prescription medicine or natural medicine?
(If yes, list) _____
_____
_____
_____

❑ ❑ 5. Do you have any disabilities (Mental or physical)? If yes, explain:_____
_____

6. Are you allergic to or have you had any reactions to the following:

❑ ❑ Local anaesthetic
❑ ❑ Antibiotics_____
❑ ❑ Medications_____
❑ ❑ Latex Rubber
❑ ❑ Any food(s) _____
❑ ❑ Any metal(s)_____
❑ ❑ Other_____

❑ ❑ 7. Do you use tobacco?_____

❑ ❑ 8. Do you consume alcohol?

9. Women only:

❑ ❑ Are you pregnant or think you may be pregnant?
❑ ❑ Are you nursing?
❑ ❑ Are you taking oral contraceptives?

yes no

10. Do you have or have you had any of the following?

❑ ❑ Cardiovascular disease (i.e., heart attack, angina, stroke, high blood pressure,)
_____
_____
❑ ❑ Cardiac pacemaker
❑ ❑ Prosthetic Heart Valve / Mitral Valve Prolapse
❑ ❑ Rheumatic fever or rheumatic heart disease
❑ ❑ Cancer _____
❑ ❑ Radiation Therapy / Chemotherapy
❑ ❑ Glaucoma
❑ ❑ Leukemia or Blood Transfusions
❑ ❑ Kidney disease
❑ ❑ Liver Disease
❑ ❑ Hepatitis A / B / C
❑ ❑ AIDS or HIV infection
❑ ❑ Epilepsy /Seizures
❑ ❑ Endocrine disorder i.e. thyroid disease (hyper/ hypo)
❑ ❑ Gained/Lost Excessive Weight
❑ ❑ Respiratory Problems (emphysema/ asthma)
❑ ❑ Lung Disease (i.e. Tuberculosis, C.O.P.D.)
❑ ❑ Cortisone or steroid treatment
❑ ❑ Joint Replacement (i.e. hip, knee) or Implant(s)
❑ ❑ Diabetes: Type I ❒ Type II ❒
❑ ❑ Stomach trouble/Ulcers
❑ ❑ Malignant hyperthermia
❑ ❑ Arthritis or rheumatism
❑ ❑ Nervous disorder
❑ ❑ Bleeding Problems or Disorder _____
_____
❑ ❑ Other relevant conditions: (Please list)
_____
_____

Dental History

1. Former Dentist _____ Address _____
Last Dental Visit_____ Last x-rays taken _____
2. ❒ ❒ Do your gums bleed when: Flossing ❒ Brushing ❒ Spontaneously ❒
3. ❒ ❒ Are your teeth sensitive to: Sweet ❒ Sour ❒ Hot ❒ Cold ❒
4. ❒ ❒ Do you have frequent headaches? Have you ever had an injury to: Neck ❒ Jaw ❒ Head ❒
5. ❒ ❒ Do you have any problems with your jaw? Clicking❒ Pain❒ Locking❒ Opening❒ Clenching❒ Grinding❒
6. ❒ ❒ Have you had any difficulty with extractions in the past?
7. ❒ ❒ Have you had orthodontic treatment?
8. ❒ ❒ Have you experienced any growth or sore spots in your mouth? If so, where?_____

I certify that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history and I consent to my physician being contacted if necessary. I authorize the dentist to perform diagnostic, dental and oral surgery procedures and services including the use of anaesthetic as are necessary. I also understand that I assume responsibility for any and all fees associated with these procedures and services. Your appointment time will be reserved especially for you. We require at least 48 hours notice if you are unable to keep your appointment. Thank you.

I agree that VSDC has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy Office and is in accordance with the Personal Health Information Protection Act, 2004.

X _____ _____

Patient (Parent) Signature: **Date:**