VULCAN **DENTAL**

NEW PATIENT FORM

Your cooperation in completing this form is essential to provide you with safe and appropriate dental care. All information is strictly confidential. Our receptionist is able to assist you with completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

MR ☐ MRS ☐ MS ☐ MISS ☐ DR ☐ THIS PATIENT IS AN: ADULT ☐ CHILD ☐

NAME: _____ PREFFERRED NAME: _____

ADDRESS: _____ POSTAL CODE: _____ CITY: _____ PROVINCE: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL: _____ BIRTHDATE: _____ SEX: _____

OCCUPATION: _____ EMPLOYER: _____ How did you hear about us? _____

Would you like to be on our **SHORT NOTICE** list for **CLEANINGS** if we get a cancellation**?** Yes ☐ No ☐

May we send you future texts and emails such as appointment reminders? Text ☐ Email ☐

INSURANCE INFORMATION (*If you have a dental plan, please complete the following*):

SUBSCRIBER: RELATION: INSURANCE COMPANY:

POLICY PLAN #: DIVISION/SECT#: SUBSCRIBER ID:

SUBSCRIBER (SECONDARY): RELATION: INSURANCE COMPANY:

POLICY PLAN #: DIVISION/SECT#: SUBSCRIBER ID:

MEDICAL INFORMATION:

Physician Name & Location: Emergency Contact: Relation to you: Phone:

List all over the counter and prescribed medications that you are now taking:

Please list any known allergies:

Do you have any of the following medical conditions? (*check all that apply***)**

☐ Asthma	☐ Bleeding Problems	☐ Cancer	☐ Congenital Heart Defect
☐ Diabetes Type I or II	☐ Heart Attack	☐ Heart Murmur	☐ Heart Valve Replacement
☐ Hepatitis	☐ High Blood Pressure	☐ HIV+	☐ Joint Replacement
☐ Kidney Disease	☐ Liver Disease	☐ Osteoporosis	☐ Pregnant
☐ Psychiatric Treatment	☐ Rheumatic Fever	☐ Sinus Trouble	☐ Stroke

Has there been any change in your general health in the last year? Yes ☐ No ☐ _____

When was your last medical examination? _____

Have you experienced any new symptoms such as a cough or illness since recent travel or otherwise? Yes ☐ No ☐

If yes, please provide details: _____

DENTAL INFORMATION:

- **Reason for today's visit:** _____
- Do you visit the dentist regularly? Yes ☐ No ☐
- Approximate last dental visit: _____
- How often do you brush your teeth? _____
- How often do you floss your teeth? _____
- Do you clench or grind your teeth? Yes ☐ No ☐
- Any clicking, locking or pain in the jaw? Yes ☐ No ☐
- Do your gums bleed when you brush? Yes ☐ No ☐
- Do you have difficulty chewing? Yes ☐ No ☐
- Are you satisfied with your teeth's appearance? Yes ☐ No ☐
- Any history of head or facial trauma? Yes ☐ No ☐
- Any growths, lumps or sore spots in the mouth? Yes ☐ No ☐
- Do you smoke? Yes ☐ No ☐
- How nervous are you during dental treatment? Extremely ☐ Very ☐ Moderately ☐ Minimally ☐ Never ☐
- Please list any other information you feel is relevant for us to be able to provide you with the best possible dental care:

This is to certify that I, the undersigned, consent to the performing of the dental and oral procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with those procedures. In the presence of insurance, I authorize the handling of my insurance and exchange of information by Vulcan Dental. It may be necessary to charge for time lost if an appointment is missed without prior notification.

X _____

(Signature) Patient ☐ Parent ☐ Guardian ☐ *(Date)*