MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

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 taken within the last two years.

Drug	Purpose	Drug	Purpose

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

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____ /_____ /_____ Date of most recent x-rays _____ /_____ / _____
Date of most recent treatment (other than a cleaning) _____ / _____ / _____
I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**

PERSONAL HISTORY

1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2.	Have you had an unfavorable dental experience? _____	☐	☐
3.	Have you ever had complications from past dental treatment? _____	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____	☐	☐

GUM AND BONE

7.	Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8.	Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11.	Have you ever experienced gum recession? _____	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____	☐	☐

TOOTH STRUCTURE

14.	Have you had any cavities within the past 3 years? _____	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20.	Do you frequently get food caught between any teeth? _____	☐	☐

BITE AND JAW JOINT

21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26.	Are your teeth developing spaces or becoming more loose? _____	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? __	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore? _____	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ___	☐	☐
32.	Do you wear or have you ever worn a bite appliance? _____	☐	☐

SMILE CHARACTERISTICS

33.	Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____	☐	☐
34.	Have you ever whitened (bleached) your teeth? _____	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
36.	Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

CLAYBURN DENTAL

Insurance Policy

Dental insurance is intended to make dentistry affordable; it was never intended to cover everything…

As a courtesy Clayburn Dental will do a complimentary insurance benefit check for our patients. However, ultimately it is the patient's responsibility for detailed information and or all the account balances incurred from services rendered.

We try our very best to gain as much information as possible from insurance carriers. However, it is becoming increasingly difficult to gain information about hidden clauses, frequencies, and limitations due to privacy policies and that we are considered a 3rd party when it comes to your individual insurance plan(s).

Clayburn Dental does not bill services according to patient's supported benefits, we bill according to services required on an individual as-needed-basis. If in doubt of insurance support, we send for predeterminations. HOWEVER, even when we receive approval for a service, in-between the time we bill and receive payment the insurance carrier could change a policy without notice rendering the approval invalid.

When changes in policies, carriers, and termination of plans occur insurance companies **DO NOT INFORM DENTAL OFFICES**. It is the patient's responsibility to know and advise us when these changes occur and again are ultimately responsible for any balances that are incurred from services rendered, as a result of the above.

Even-though we have extensive knowledge with insurance carriers it is to your benefit to READ your employee handbook and understand your covered services. Ultimately, it's a contract between you and your employer. We encourage you to talk to your insurance carrier regarding the coverage details of your plan. This will avoid any disappointment regarding changes and or the decline in payment of services.

In some cases, insurance carriers only correspond with their members; in this case you need to inform Clayburn Dental so that we can assist you in understanding these correspondences.

As a patient of Clayburn Dental, I have read and understand the above insurance policy. Any treatment that my insurance does not pay or exceeds the limits of my plan will be my responsibility and billed directly to me.

Date: _____ Patient Signature: _____

Treatment Coordinator Signature: _____

Patient Agreement

Welcome to Clayburn Dental Centre. We are pleased that you have chosen us to be your provider of quality dental care.

To ensure that we can provide the best customer service to our patients the following policies are in effect:

- Any change to your address, phone number, email address and insurance coverage must be provided the day of treatment.
- Changes to your medical/dental history particularly in regards to medications, allergies, recent hospitable visits, and glucose and INR numbers must be updated with your dental professional.
- It is contraindicated to treat patients in the **last half** of the 3rd trimester of pregnancy, and patients who have not taken their required premedication due to medical conditions.

Payment Options

Clayburn Dental is pleased to offer you the following payment options:

☐ **Option 1:** Payment is due in full on the day treatment is rendered. We accept Cash, Direct Debit, Visa and MasterCard.

☐ **Option 2:** You may prefer to pay for your dental work on your treatment day and have your insurance company reimburse you directly. Clayburn Dental will assist you in submitting the necessary documents to your insurance carrier.

☐ **Option 3:** Leave your Credit Card information on file. We will submit your insurance claim directly to your insurance provider and you will pay the balance of the dental fee as "indicated" by your insurance provider. Once your insurance provider has paid us their portion, Clayburn Dental will process any balance to your credit card.

To ensure the safety of your Credit Card information we keep on file we use SafePay. SafePay is a service provided by our Credit Card Terminal Provider, Federated Gateway Ltd. – none of your personal Credit Card information is held at Clayburn Dental.

Patient Consent

I hereby give Clayburn Dental Centre permission to speak with or provide written or electronic information to my significant other/spouse/parent/guardian about any information that is needed in the opinion of the Clayburn Dental Centre. Name of Third party(s) _____

Patient Signature: _____

☐ I agree to receive electronic communication from Clayburn Dental including appointment reminders, updates and promotions regarding their products. I am aware that I can opt-out or withdraw my consent at any time.

☐ I am aware that a comprehensive copy of the Clayburn Dental Privacy Policy can be found at www.clayburndental.com/our-abbotsford-dentist-practice/privacy-policy/.

☐ I have read and agreed to all of the above policies as outlined.

Patient Name: _____ Date: _____

Patient Signature: _____