Driftwood Health Services Inc.
10-2401 Cliffe Avenue
Courtenay, BC V9N 2L5

All Patient Information is Strictly Confidential

Name:_____Date: _____

Please tell us how you heard about us: Radio ☐ Coffee News ☐ Internet ☐ Yellow Pages ☐ Family/Friend ☐ If Family/Friend referred you to Driftwood Dental, please share their name here:_____

Do you experience anxiety or become tense during dental appointments? ☐ Yes ☐ No

Select your consent for electronic communication: ☐ Email ☐Text ☐ Both ☐ No thank you.
(Note: We use text/email for confirmation of your appointment. We do not send newsletters.)

INSURANCE: In order to prevent misunderstandings about dental insurance, please note that all professional services provided are the financial responsibility of the patient or legal guardian. By initialling here _____ I give permission for Driftwood Dental to submit my claim electronically and/or contact my insurance provider for processing. Be aware that due to insurance provider privacy laws, we're limited in our ability to access claims or details of your plan. Full payment of the patient portion for treatment is due the day services are rendered.

APPOINTMENTS: Appointment times are reserved especially for you. If you're unable to attend an appointment please provide two business days' notice to avoid a **short notice or missed appointment fee of $100 per hour scheduled** for general dental or Hygiene appointments. Short notice change fees for sedation appointments calculated separately.

PERMISSION TO TREAT: This is to certify that I, the undersigned, consent to dental and oral surgery procedures as determined necessary or advisable, including the use of local anesthesia. I authorize the release of any records that are relevant to the processing and payment of this claim held by the service provider, any appropriate health professional licensing or regularity body for the purpose of administrative audit.

Name: _____ Signature _____ Date _____
Patient/Guardian as applicable Day/Month/Year

Address: _____

_____

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CONFIDENTIAL DENTAL HISTORY

NAME: _____ Date: _____

How long since your last dental visit? _____ What was done at that time? _____

_____

Do your gums feel tender or swollen? Yes____ No____
Have you ever received local anaesthetic (freezing?) Yes____ No____
Have you ever been given general anaesthetic? Yes____ No____
Were there any complications due to the anaesthetic procedures? Yes____ No____

Please specify_____

Are you aware of any lump or swelling in your mouth? Yes____ No____
Have you received oral hygiene instruction for the care of your teeth and gums? Yes____ No____

Have you had treatment from a dental specialist? If yes, what type? _____

_____

On a scale of 1-10 how would you rate your smile? (one is low, ten is high) _____

What would make it a 10? _____

_____

Are you eager to keep your natural teeth? Yes____ No____

Are you tense during dental visits? Yes____ No____

If yes, please circle your rating (One is low; five is high) 1 2 3 4 5

Are you interested in sedation for your dental treatments? Yes____ No____

Do you currently experience: (Check where appropriate)

☐ Loose Teeth
☐ Snoring
☐ Neck Pain
☐ Missing Teeth
☐ Spaced or Crooked teeth
☐ Bleeding Gums
☐ Sensitive Teeth
☐ Ear Ache
☐ Unexplained Nosebleed
☐ Unsatisfactory Dentures
☐ Sore Gums
☐ Bad Breath
☐ Headache
☐ Gagging
☐ Popping or clicking in the jaw joint