PATIENT INFO.

PACIFIC SPIRIT DENTAL CENTRE

215 - 2150 WESTERN PARKWAY
VANCOUVER, BRITISH COLUMBIA
CANADA V6T 1V6
T: 604.224.2411 F: 604.224.6590

WELCOME TO OUR OFFICE

Please print neatly and fill out as accurately as possible.

(A) PERSONAL INFORMATION

Miss Ms
Surname Mr. Mrs. Dr. _____ Given Names _____

Telephone: Residence _____ Work _____

Cell _____ Email _____

Address _____

City / Province _____ Postal Code _____

Date of Birth: Day _____ Month _____ Year _____

Person responsible for account: _____

(B) DENTAL INSURANCE INFORMATION

Do you have dental insurance coverage? Yes No If yes, name of carrier _____

Name of insured _____ Employer _____

ID# _____ Group# _____ Certificate# _____

Div. _____ Coverage(%) A _____ B _____ C _____ D _____

Limits/deductibles _____

_____

Are you covered under a second dental plan? Yes No If yes, name of carrier _____

Name of insured _____ Employer _____

ID# _____ Group# _____ Certificate# _____

Div. _____ Coverage(%) A _____ B _____ C _____ D _____

Limits/deductibles _____

_____

Payment for services rendered is expected at the end of each appointment. Please be aware of any limitations to your plan since responsibility for your account belongs to you. Our staff will gladly handle your insurance forms.

(C) DENTAL QUESTIONNAIRE

1. Are you in pain or discomfort? Yes No _____
2. What are your reasons for visiting our office? _____

_____

_____

_____

_____

_____

3. Please give the approximate date of your last dental checkup _____

4. Are you satisfied with the way your teeth work eg. chewing, speech etc.? Yes No _____

5. Are you satisfied with the aesthetics (looks) of your teeth? Yes No _____

6. Do you experience any of the following problems?
   - ☐ swelling, sores or lumps in mouth
   - ☐ sensitive teeth
   - ☐ grinding or clenching habits
   - ☐ frequent headaches
   - ☐ clicking or popping noises from jaw joints
   - ☐ tension or pain from head, neck or shoulders
   - ☐ bleeding gums
   - ☐ loose teeth
   - ☐ ringing in the ears
   - ☐ balance problems

7. Are you presently being treated by a physiotherapist or chiropractor for any neck, shoulder or spinal problems? Yes No _____

8. Have you ever had any of the following treatments?
   - ☐ bridges or crowns
   - ☐ partial dentures
   - ☐ extractions
   - ☐ periodontal (gum) treatment
   - ☐ orthodontics (braces)
   - ☐ complete dentures
   - ☐ surgery in mouth
   - ☐ root canal fillings

9. Have you ever had an unpleasant experience in a dental office? Yes No _____

10. Does any part of dental treatment make you feel nervous or anxious Yes No _____

11. Who may we thank for referring you? _____

I, the undersigned, consent to the dental treatment agreed upon and that I am responsible for payment of the corresponding fees. I understand that a possibility of complication exists for each treatment.

Signature: _____ Date: _____

Signature of parent or guardian (if under 18):

Dentist's comments: _____

Dentist's signature: _____ Date: _____