KETTLE VALLEY
FAMILY DENTAL

First Name: _____ Last Name _____ Date of Birth: _____

Phone Number: _____ Address: _____ Postal Code: _____

Email Address: _____ Gender: Male ☐ Female ☐ Other ☐

Emergency Contact Name: _____ Emergency Contact Phone Number: _____

Please circle any of the following services that you may be interested in:

Botox Invisalign Whitening Veneers Implants Dentures

Are you interested in a complimentary Skin Analysis? YES NO

INSURANCE INFORMATION

Policy Holder Name: _____ Date of Birth: _____

Dental Insurance Provider: _____ Employer: _____

Dental Insurance Policy/Group Number: _____ ID# _____

Coverage/Percentage: _____

MEDICAL HISTORY

Have you had any major surgeries? If yes, please specify and provide dates: YES NO

_____

_____

Please list ALL medications, vitamins, supplements that you are currently taking and note what condition you are taking them for.

Medication: Reason for use:

_____ _____

_____ _____

_____ _____

_____ _____

DENTAL INFORMATION

Are you happy with the appearance of your teeth? YES NO

If no, please specify what you would like to change: _____

Are you having any dental problems or discomfort with your mouth that needs immediate attention?

If yes, please specify: _____ YES NO

Have you been seeing a dentist regularly? YES NO

When was your last visit to the dentist? _____

When was the last time you had dental x-rays taken? _____

Name of the previous Dentist or Dental Office? _____

Initials: _____

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PLEASE CHECK ALL THAT APPLY:

HEART/BLOOD
- ☐ Congenital Heart Disease
- ☐ Do you take blood thinners?
- ☐ Rheumatic Fever
- ☐ Irregular or rapid heartbeat
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Heart attack
- ☐ Stroke
- ☐ Endocarditis
- ☐ Joint replacement
- ☐ Problem with heart valve
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Heart transplant
- ☐ Blood clots or Thrombosis
- ☐ Anemia
- ☐ Sickle Cell Disease or Trait
- ☐ Hemophilia
- ☐ Transfusion
- ☐ Other heart, vessel or blood disorder: _____

HEAD & NECK
- ☐ Frequent or severe nosebleeds
- ☐ Difficulty swallowing
- ☐ Glaucoma
- ☐ Headaches
- ☐ Sinusitis
- ☐ Injuries to head, neck, jaw, or teeth: _____
- ☐ Other: _____

MUSCLES/BONES
- ☐ Sjogren's Syndrome
- ☐ Arthritis
- ☐ Chronic back pain
- ☐ Other: _____

URINARY TRACT
- ☐ Kidney Disease
- ☐ Renal Disease
- ☐ STD
- ☐ Other: _____

DIGESTIVE SYSTEM
- ☐ Liver Disease
- ☐ Ulcers
- ☐ Jaundice
- ☐ Frequent heartburn
- ☐ Other: _____

RESPIRATORY
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Bronchitis
- ☐ Persistent cough
- ☐ Shortness of breath
- ☐ C.O.P.D.
- ☐ Other: _____

ENDOCRINE
- ☐ Low Thyroid
- ☐ Cushing's Syndrome
- ☐ Parathyroid Condition
- ☐ Diabetes
- ☐ Other: _____

NERVES
- ☐ Epilepsy
- ☐ Seizures
- ☐ Multiple Sclerosis (MS)
- ☐ Trigeminal Neuralgia
- ☐ Chronic pain
- ☐ Other: _____

MENTAL HEALTH
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric treatment or counselling
- ☐ Other: _____

CANCER
- ☐ Leukemia
- ☐ Benign tumors/growths
- ☐ Other: _____
- ☐ Treatment: _____

ALLERGIES

Allergic/bad reaction to:
- ☐ Dental Anesthetics
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Latex
- ☐ Metals
- ☐ Other: _____

FAMILY HISTORY

Has anyone in your immediate family ever had:
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Tuberculosis (TB)
- ☐ Depression
- ☐ Other: _____

OTHER
- ☐ HIV
- ☐ Organ transplant
- ☐ Methamphetamine
- ☐ IV drugs
- ☐ Herpes Simplex (Cold Sores)
- ☐ Hepatitis A B C

WOMAN

Are you or is there a possibility that you may be pregnant?

YES NO

Any form of birth control?

YES NO

Initials: _____

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PLEASE CHECK ALL OF THE FOLLOWING SYMPTOMS YOU MAY HAVE:

DENTAL

- ☐ Bleeding while brushing or flossing?
- ☐ Tendency to faint
- ☐ Nervous in chair
- ☐ No Fluoride
- ☐ Do you take bisphosphonates?
- ☐ Wheelchair
- ☐ Gag reflex
- ☐ Do not recline chair
- ☐ Sensitivity to any of the following, biting, brushing, or temperature?
- ☐ Have you ever required antibiotics before any dental treatment?
- ☐ Do you have areas where food gets stuck?
- ☐ Do you have a reaction to Epinephrine?
- ☐ Do you have diabetes? If yes, specify type? _____
- ☐ Do you have side effects with local anesthetic?
- ☐ Do you suffer from pain or swelling of your gums?
- ☐ Do you smoke, vape, use other tobacco products, use marijuana or any recreational drugs? If yes, please specify:

  _____
- ☐ Other:

  _____

TMJ (JAW)

- ☐ Jaw pain
- ☐ Clicking or popping of jaw joints
- ☐ Grating sounds in jaw joint
- ☐ Pain in cheek muscles
- ☐ Uncontrollable jaw movements
- ☐ Jaw locks open/shut
- ☐ Clenching or grinding of teeth
- ☐ Deviates to one side on opening or closing

THROAT

- ☐ Frequent coughing or clearing
- ☐ Feeling of foreign object in throat
- ☐ Sore throat without infection
- ☐ Voice changes
- ☐ Laryngitis

NECK

- ☐ Lack of mobility
- ☐ Stiffness
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Arm or finger pain/numbness
- ☐ Neck pain
- ☐ Tired or sore neck muscles

MOUTH

- ☐ Abnormal opening/bad bite
- ☐ Missing teeth
- ☐ Excessive mouth breathing

HEAD AND FACE

- ☐ Pain in forehead
- ☐ Pain in the temporal area
- ☐ Tension headaches
- ☐ Migraine headaches
- ☐ Sinus headaches
- ☐ Back of head headaches
- ☐ Scalp tender to touch

NASAL

- ☐ Sinus pain
- ☐ Sinus problems
- ☐ Post-Nasal drainage
- ☐ Allergies

EYES

- ☐ Pain in/around eyes
- ☐ Bloodshot eyes
- ☐ Sensitivity to light
- ☐ Tearing of eyes
- ☐ Blurred vision
- ☐ Pressure behind eye

EARS

- ☐ Ear pain without infection
- ☐ Decrease hearing
- ☐ Clogged, itchy, or stuffy
- ☐ Ringing or buzzing
- ☐ Dizziness

Are there any other symptoms or conditions that we should be aware of? If so, please specify:

_____

_____

HOW DID YOU HEAR ABOUT OUR CLINIC? WE WOULD LOVE TO KNOW! _____

I certify that the above Health History has been completed to the best of my knowledge.

I understand that this information will be kept confidential.

Patient Name: _____ **Signature:** _____ **Date:** _____

KETTLE VALLEY
FAMILY DENTAL

103-5315 Main St
Kelowna, British Columbia, V1W 4V3
(778) 477-0411

PATIENT AGREEMENT

This Patient Agreement contains important information about your dental treatment at Kettle Valley Family Dental. By signing this patient agreement, you acknowledge that you have read and agree to all the terms and conditions contained herein. Please read carefully and ask questions you may have.

1. Kettle Valley Family Dental will be presenting the best dental treatment options and other options if applicable to you and/or your family and plan to treat you according to your dental and whole-body needs and requirements.

2. Kettle Valley Family Dental uses well-evaluated dental products and medications to provide you and/or your family with the dental treatment you need. All products have been studied and are known to be safe for use. This does not rule out the possibility of adverse or allergic reactions that you may have, or relevant medical health history information intentionally or unintentionally not disclosed.

3. Kettle Valley Family Dental is in no way associated or affiliated with any insurance company. This means we have no direct contact with your insurance company and have no inside information, ability, or control as to what your assistance plan will pay for benefits that are listed in your client packet. We determine treatment needed before knowing any of your insurance details.

4. Your insurance is a benefit to you and is there to assist you with the costs of dentistry. We strongly recommend that you find out what your insurance coverage is, as per your insurance contract.

5. Kettle Valley Family Dental has extended the courtesy to direct bill the insurance company on behalf of their patients. On the date of service, we will submit the claim to insurance and collect the remaining balance from the patient. Once insurance has paid a portion, it is the responsibility of the patient to pay any outstanding amount. Kettle Valley Family Dental takes no responsibility in what the insurance deems to pay for the service provided.

I HAVE READ THIS PATIENT AGREEMENT, FULLY UNDERSTAND, AND AGREE TO ALL ITS TERMS AND CONDITIONS.

Patient Name: _____ Signature: _____ Date: _____