WestcoastSmile
Dental Studio and Whitening Spa

Date _____

WELCOME TO OUR OFFICE

REGISTRATION INFORMATION

Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with completion of this form.

REGISTRATION INFORMATION

Name: Last, First	Initial	**Dr.** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss** ☐		
Address		**City / Province**	**Postal Code**	
Reason for Today's visit? **Examination** ☐ **Emergency** ☐ **Other** ☐ (Please explain)				
Home Phone	**Cell Phone**	**Email Address**		
Business Phone	**Ext.**	**Employer**	**May we call you at work?** **Yes** ☐ **No** ☐	
Occupation				
Date of Birth [mm/dd/yyyy]	**Age**	**Sex**	**Marital Status**	**Name of Spouse**
Are other family members patients at our office? **Yes** ☐	**Names**			
Family Physician			**Phone**	
In case of Emergency, please contact			**Phone**	

FINANCIAL AND CREDIT INFORMATION

Person responsible for account: **Self** ☐ **Spouse** ☐ **Other** ☐			
Name: Last, First	**Initial:**	**Home Phone**	
Address:		**City / Province**	**Postal Code**
Family Physician		**Phone**	

PRIMARY DENTAL INSURANCE (if information available) SECONDARY DENTAL INSURANCE

Subscriber's Name (if not your plan) **Emp./Group Policy holder**	**D.O.B.** [mm/dd/yyyy]	**Subscriber's Name** **Emp./Group Policy holder**	**D.O.B.** [mm/dd/yyyy]
Insurance Company	**Phone**	**Insurance Company**	**Phone**
Emp./Group Policy No.	**Cert. No.**	**Emp./Group Policy No.**	**Cert. No.**

DENTAL HISTORY Please check YES or NO to each question. If unsure of a question, please consult the dentist

Is there a dental problem you would like treated immediately? Yes ☐ No ☐		
Date of your last dental visit	Last dental cleaning?	Last X-rays
1. Reason for your appointment? Checkup/Cleaning ☐ Smile Enhancement ☐ Invisalign ☐ Implants ☐		
2. Have you ever had any of the following?		
• Periodontal Treatment (treatment of gums)?		Yes ☐ No ☐
• Orthodontic Treatment (to straighten or align teeth)?		Yes ☐ No ☐
• A bite plate or any other appliance?		Yes ☐ No ☐
• Your bite adjusted or teeth ground?		Yes ☐ No ☐
• Oral Surgery (surgery in or about the mouth/jaw joint or implant surgery in one or both of your jaw joints?		Yes ☐ No ☐
3. How often do you brush your teeth?	Do you feel you have bad breath?	Yes ☐ No ☐
4. Do you use dental floss? Yes ☐ No ☐	How often?	
5. Do your gums bleed when brushing or eating?		Yes ☐ No ☐
Do you suffer from pain or swelling of your gums?		Yes ☐ No ☐
6. Does food catch between your teeth?		Yes ☐ No ☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure?		Yes ☐ No ☐
8. Have you ever experienced any of the following jaw problems?		
• Popping/clicking in your jaw joints?		Yes ☐ No ☐
• Pain in your jaw joints, around your ear, or side of your face?		Yes ☐ No ☐
• Difficulty in opening or closing?		Yes ☐ No ☐
• Pain when teeth are clenched?		Yes ☐ No ☐
• Pain or difficulty when chewing?		Yes ☐ No ☐
9. Do you have any of the following habits?		
• Clenching or grinding your teeth while awake or asleep?		Yes ☐ No ☐
• Biting your cheeks or lips?		Yes ☐ No ☐
• Mouth breathing while awake or asleep?		Yes ☐ No ☐
• Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)?		Yes ☐ No ☐
10. Do you have any emotional concerns about having dental treatment?		Yes ☐ No ☐
11. Are you unhappy with the appearance of your teeth?		Yes ☐ No ☐
What would you like to see changed?		
12. Have you ever had an upsetting experience in a dental office?		Yes ☐ No ☐
Any complications during or following dental treatment		Yes ☐ No ☐
Do you have any questions or concerns?		Yes ☐ No ☐

HEALTH HISTORY Please check YES or NO to each question.

1. Are you being treated for any medical condition at present or within the past year? If yes, please explain?	Yes ☐ No ☐
2. Have there been any changes in your general health in the past year?	Yes ☐ No ☐
3. When was your last visit to a physician?	When was your last complete physical examination?
4. List any PRESCRIPTIONS and NON-PRESCRIPTION medications you are taking or have recently taken (including birth control pills)	

HEALTH HISTORY (continued)

5. Have you ever had any adverse or unusual reaction to any medications or injections? (e.g. penicillin or other antibiotics, aspirin, codeine, local anesthetic "dental freezing")**?** **Yes** ☐ **No** ☐
Please explain:

6. Have you ever been advised against taking any specific type of medication? **Yes** ☐ **No** ☐

7. Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal allergies)**?** **Yes** ☐ **No** ☐

8. Have you ever fainted during a dental or medical treatment? **Yes** ☐ **No** ☐

9. Do you bleed excessively from a cut or injury, bruise easily or have any blood disorders? **Yes** ☐ **No** ☐
Please explain:

10. Are you on cortisone or steroid therapy? or, are you on a diet pill therapy? **Yes** ☐ **No** ☐

11. Do you have any artificial joints (e.g. hip, knee)**?** **Yes** ☐ **No** ☐

12. Have you ever been advised to take antibiotics before dental treatment? **Yes** ☐ **No** ☐

13. Do you have a heart murmur, valve dysfunction (mitral valve prolapse or artificial heart valve) **or have you ever had Rheumatic Fever?** **Yes** ☐ **No** ☐

14. Do you have, or have you ever had, any heart or blood pressure problems (heart or stroke)**?** **Yes** ☐ **No** ☐
Please explain:

15. Do you have, or have you ever had, any chest pain, shortness of breath or any heart palpitation without exertion? **Yes** ☐ **No** ☐

16. Are you presently suffering from any infectious diseases? **Yes** ☐ **No** ☐

17. Do you have any conditions that could affect your immune system (e.g. arthritis, AIDS, HIV infection, lupus, inflammatory bowel disease, Crohn's disease)**?** **Yes** ☐ **No** ☐
Please explain:

19. Indicate which of the following you presently have, or ever had: (Please check all that apply)

Asthma ☐	**Epilepsy or Seizures** ☐	**Tuberculosis** ☐	**Glandular Disorders** ☐
Bronchitis ☐	**Hepatitis** ☐	**Diabetes** ☐	**Organ Transplant/Medical Implant** ☐
Emphysema ☐	**Jaundice** ☐	**Kidney Disease** ☐	**Stomach/Intestinal Problems** ☐
Lung Disease ☐	**Liver Disease** ☐	**Thyroid Disease** ☐	**Ulcers** ☐

20. Do you, or did you smoke? **Yes** ☐ **No** ☐
Do you drink alcoholic beverages on a regular basis? **Yes** ☐ **No** ☐
Do you use recreational drugs? **Yes** ☐ **No** ☐

21. WOMEN ONLY: **Are you pregnant?** **Yes** ☐ **No** ☐ **If pregnant, delivery date?** **Are you breast feeding?** **Yes** ☐ **No** ☐

22. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, heart disease)**?** **Yes** ☐ **No** ☐

23. Do you currently have, or ever had in the past, any disease, condition or problem not listed above? **Yes** ☐ **No** ☐

NOTES:

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical/dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical/dental history. Should there be any change in my health status in the future, I will advise this dental office. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of the information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____

(signature) **Patient** ☐ **Parent** ☐ **Guardian** ☐ (print name of guardian)

Reviewed by Treating Dentist: _____ **Date:** _____

Welcome to ***WestcoastSmile Dental Studio and Whitening Spa***, Dentistry for your Life Style and Life Smile. Our mission is to offer our patients the highest standard of oral wellness and dental care with staff that are guided by the highest ethics and commitment to excellence in a serene spa-like environment.

To ensure the continued partnership between ***WestcoastSmile Dental Studio*** and our patients, we ask that you take a moment to review our business guidelines. Our objective is to have a payment policy that allows you to receive the care that benefits your health and beauty in a timely manner.

Financial Options and Payment Policy

A. Method of Payment: All accounts are settled on the day of service. For your convenience we offer many payment options, we accept cash, debit card, MasterCard, Visa, American Express, Patient Link and other 3rd party financial vehicles which offeraa unique and innovative way to access credit for restorative and cosmetic dental treatment.

B. Dental Insurance: We will help you work with your insurance company and as a courtesy to our clients our office will be happy to provide and submit all paperwork to expedite reimbursement in a timely manner. We use internet submission which allows your prompt reimbursement from your provider, often within a few days.

IMPORTANT NOTE: We are guided by privacy laws, thus we rely solely on our patients to maintain a relationship with his/her dental insurance company and to provide our office with the most accurate insurance information. Your insurance is solely a relationship between you and your provider. Given these restrictions we ask that all treatment be paid for at the time of service.

C. Deposits: a deposit of 50% for all labs processed and custom restorative dental services is required. In addition, deposit on most appointments requiring over an hour of doctor chair time are to be paid at the time of booking that appointment.

Appointment Scheduling Policy

When you make an appointment we are reserving a state of the art operatory room and highly trained staff for your particular needs at a specified time. We prepare your room and your records, specific instruments and equipment are sterilized and readied for you only.

D. Smile Reminder Automated Digital Service: We offer convenient email/text reminders to our clients through our email/text contact service. When you receive your *SMILE REMINDER* by email please open and use the easy click to **Confirm Your Appointment**. If we do not get a response from *SMILE REMINDER* we will try to contact you by phone and email. If we still cannot confirm your appointment we will assume you are not available and will cancel your appointment. It is ultimately your responsibility to attend your appointment.

E. Notice To Reschedule or Cancel:aIf you must reschedule your appointment we require **2 Business Days Notice** so that we have enough time to schedule another patient into that time. We appreciate this courtesy as it opens up the appointment for another patient that may need it. Notification is accepted by phone during office hours. If you notify us during off-hours then the phone message must be accompanied by email message sent to info@westcoastsmile.com.
You must notify us within 2 business days of appointment or there will be a fee charged as follows:

Hygienist:	$ 75.00 per hour(or portion thereof) booked
Dentist:	$175.00 per hour(or portion thereof) booked

F. Missed Appointment or " No-Show": If you completely miss an appointment that you have confirmed or cancel the day of your appointment you will be charged **up to the full value of the appointment**. (We understand that emergencies and unforeseen circumstances do arise and each occurrence will be assessed individually)

I authorize ***J. Norden Inc.*** to charge my credit card for any cancellation or missed appointment fees, outstanding balances, or deposits required for pre-booked treatment I have accepted from ***WestcoastSmile Dental Studio and Whitening Spa***.

_____ ___ / ___ _____

Credit Card # Expiry Date

Cardholder Name _____ Signature _____