NELSON AVENUE DENTAL CLINIC

Patient Information Form

How did you find out about our office? _____

What are your main dental concerns?

_____

_____

_____

Contact information:

Legal Name:(First) _____ (Last)_____ (Middle)_____

Preferred name: _____ Preferred Title (eg. Ms./Dr./Mr.)_____

Date of Birth: (dd/mm/yyyy) _____ Gender:_____

Address:

_____

Preferred Phone: _____ Email address: _____

Emergency Contact & Number:

_____

Would you like to add family members to your account? Yes☐ No☐

Name(s):

_____

Dental Insurance Information:

Insurance plan name: _____ Policy No: _____

Plan no/description: _____ Dep No: _____

Holder's Name: _____ Holder's DOB: _____

Holder's Place of Employment: _____

Dental History:

When was your last dental visit? Date (dd/mm/yyyy):_____

Have you had radiographs (x-rays) in the last year? Yes☐ No☐

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www.nelsonavedental.com

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Health History:

Family physician name:_____ Family physician phone: _____

Personal Health Number: _____

Do you consider yourself to be in good health? Yes☐ No☐

If no, please provide further information:

_____

_____

Do you see any medical specialists? Yes☐ No☐

If yes, please provide further information:

_____

_____

Do you have any allergies to medications? Yes☐ No☐

If yes, please provide further information:

_____

_____

Have you had any accidents or surgeries in the last 5 years? Yes☐ No☐

If yes, please provide further information:

_____

_____

Is there any chance that you may be pregnant? Yes☐ No☐

Please list any general health or mental health conditions that we should be aware of (e.g. Diabetes, Hypertension, Hepatitis, Bleeding Disorders, Heart Attack, Stroke):

_____

_____

_____

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Medication History:

Please provide us with a complete list of any medications, including herbs, vitamins and supplements, which you are currently taking:

_____

_____

_____

_____

Have you ever had an adverse reaction to medications or antibiotics? Yes☐ No☐
If yes, please describe what happened:

_____

Do any of your medications make you "drowsy"? Yes☐ No☐
If yes, please list which ones:

_____

Have you had joint or heart valve replacement, or congenital heart defects? Yes☐ No☐

If yes, please explain:_____

Do you take any medicine to strengthen your bones (eg. Bisphosphonates)? Yes☐ No☐
If yes, please list which ones:

_____

Date: (dd/mm/yyyy) _____ Patient signature: _____

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Information Privacy:

Nelson Avenue Dental is dedicated to ensuring the privacy of your personal information. All of the information that is collected is for the purpose of the provision of your dental care and will not be used for marketing or advertising. Our office utilizes Digital Dental Records and is operating under a secure network with multiple levels of security against the breach or loss of your information. All paper records will be kept in a secure location in the office, or will be digitized and then disposed of in a secure manner. As part of the information collection process, and routine for your dental care, our office will need to communicate with other health care professionals, legal advisors and insurance agents, on your behalf. Our office complies with the Personal Information Protection Act (PIPA) of British Columbia. For more information please read:
http://www.cio.gov.bc.ca/local/cio/priv_leg/documents/pipa/guidepipaview.pdf

If for any reason you feel that there has been a breach in your privacy, please contact our privacy officer: Dr. David P. Alfaro, 250-354-4244

Informed Consent:

It is your right to fully understand all of your treatment options, their risks and benefits, and your financial responsibilities for those treatments, prior to initiating any dental care with us at Nelson Avenue Dental. A discussion of the treatment plan and a verbal agreement to proceed with care can suffice as informed consent. Nelson Avenue Dental may ask, however, that you read additional information, including, but not limited to, a consultation report, scientific information, and treatment information sheets, and then have you sign acknowledgement of informed consent, either in writing or electronically, prior to initiating any treatment. If ever you are unclear on any part of your treatment, please notify us immediately, and your treatment will be halted until you feel that you are informed enough to move forward. Nelson Avenue Dental reserves the right to decline treatment if we feel that informed consent, or consensus on a treatment plan, is unattainable.

Patient Signature:_____ Date: _____

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