MILL BAY DENTAL HEALTH
AND IMPLANT CENTRE
EST 1975

# Welcome

## THANK YOU FOR CHOOSING OUR DENTAL PRACTICE.

Our mission is to understand your dental needs and deliver a pleasant and personalized dental experience. By marrying general, cosmetic, and reconstructive dentistry, our Dentists, hygiene team, and onsite Periodontist strive to provide a wellness driven, multi-disciplinary approach to dentistry that will surely enhance your dental experience.

## OUR COMMITMENT TO YOU

### FRIENDLY AND PERSONABLE DENTAL TEAM

We are committed to the highest quality dental care. Our office is an inviting atmosphere aimed at making you feel comfortable and welcome.

### PERSONALIZED, QUALITY DENTAL CARE

We provide dental treatment in a caring manner, so you can enjoy a lifetime of oral health. Our doctor and our team care about our patients and want to provide you with personalized care.

### PROFESSIONAL, REPUTABLE EXPERTISE

Our doctors and our team members stay current with the latest procedures and dental technology. Our clinical excellence and quality assurance standards put our patients at ease so they can focus on simply getting to know their doctor and team members.

### THE VALUE OF BEING OUR PATIENT

Attending regular dental visits is one of the best ways to prevent cavities and gum disease. During your visit to our practice your dentist and hygienist will develop a preventative plan especially for you. Keeping your mouth healthy can save you time and money down the road.

### COLLABORATION WITH DENTAL SPECIALISTS

Our close working relationship with these specialty doctors helps us to provide dental care

# *Treating everyone like family*

that is seamless and consistent. Collaboration also provides educational opportunities and professional growth as we work together on behalf of our patients' needs.

### FLEXIBLE HOURS TO FIT YOUR SCHEDULE

We know your time is valuable, so we strive to have convenient hours to fit your needs. We also offer Saturday appointments for our patients.

### TECHNOLOGY

We welcome technology and all of the benefits we can provide our patients by investing in technology.

### COMMUNITY INVOLVEMENT AND SUPPORT

We are committed to our beautiful community. You will find us participating in community events, neighborhood festivals, the Children's Dental Health Program, providing learning resources and teaching good dental hygiene at local schools and daycare centers.

## OUR SERVICES

### GENERAL SERVICES

General Restorative Treatment

Porcelain Veneers and Crown and Bridge

Porcelain Onlays and Inlays

Endodontic Treatment

Oral Surgery

Preventive Hygiene Services

### SPECIALTY SERVICES

Implant Dentistry

Gum Grafting

Porcelain Veneers and Crown/ Smile Design

Clenching and Grinding

Gum Disease Therapy

Teeth Whitening

Dentures and Partials

Invisalign Clear Braces

### THANK YOU FOR SUPPORTING OUR TEAM

The biggest compliment that we can ever receive is when our patients value and trust the service that we provide enough to invite their friends and family members to join our practice.

For more information about our practice and services visit
**www.millbaydentistry.com**

PO Box 105, Suite 380 2720, Mill Bay BC, V0R 2P0 • T: 250 743-9511 •

# *Welcome To Our Practice*

**NEW PATIENT INFORMATION FORM**

MILL BAY DENTAL HEALTH AND IMPLANT CENTRE

First Name: _____ Last Name: _____

Date of Birth: _____ Marital Status: _____

Personal Health Number (Care Card): _____

Address: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

How do you prefer to be contacted? ☐ Cell ☐ Home Phone ☐ Email ☐ Work Phone:

Who do we call in case of emergency? Name: _____ Phone: _____

Who can we thank for referring you (how did you find out about our practice)?:

☐ Patient: _____ (Relationship) _____ ☐ Website

☐ Online / Google Search ☐ News Paper Ad ☐ Walk by ☐ External Signage

☐ Social Media

**Insurance Information**

Insurance Carrier: _____ Policy number: _____

ID number: _____ ☐ Subscriber ☐ Insured

**Personal History**

It is important to us that we meet your needs and address your primary concerns therefore we ask you to share the following information leading into your appointment today:

What is your primary concern today: _____

When did this become a concern: _____

How would you describe your last dental experience: _____

What prevented you from returning to your former Dentist?: _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Do you have or have you ever hadever have Braces, Orthodontics, Treatment or Upper Bite Adjustment?: ☐ Yes ☐ No



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## DENTAL HISTORY



| *Please answer Yes or No to the following:* | YES | NO |
|---|---|---|
| **Gum and Bone** | | |
| Do your gums bleed or are they painful when brushing or flossing? | ☐ | ☐ |
| Have you ever been treated for gum disease or been told you have lost bone around your teeth? | ☐ | ☐ |
| Is there anyone with a history of periodontal disease in your family? | ☐ | ☐ |
| Have you ever experienced gum recession? | ☐ | ☐ |
| Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? | ☐ | ☐ |
| **Tooth Structure** | | |
| Have you had any cavities within the past 3 years? | ☐ | ☐ |
| Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? | ☐ | ☐ |
| Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? | ☐ | ☐ |
| Do you frequently get food caught between any teeth? | ☐ | ☐ |
| **Smile Characteristics** | | |
| Is there anything about the appearance of your teeth that you would like to change? | ☐ | ☐ |
| Have you ever whitened (bleached) your teeth? | ☐ | ☐ |
| Have you felt uncomfortable or self conscious about the appearance of your teeth? | ☐ | ☐ |
| Have you been disappointed with the appearance of previous dental work? | ☐ | ☐ |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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**Your Privacy is Always Assured**

Privacy of our patient's personal information is important to us. Personal information is necessary for providing professional oral health care services to you and information necessary to administer your dental treatment.

I authorize communication of this personal information by mail, electronic and verbal means. Personal information includes clinical records, X-rays, study models, photographs of you and your teeth, mouth, smile and face, and general health information obtained from a medical history review, insurance information, phone numbers and email addresses. Clinical information and photographs, x-rays may also be used for long-term follow-up and research purposes, as well as for education or teaching purposes.

Your personal information will only be shared with those who have a need to know and specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include referring dentists, other dental specialists, physician(s), dental laboratories and insurance carriers.

I certify that I have read and understand this document.

Signature/Parent or Guardian: _____ Date: _____

Signature/Parent or Guardian: _____ Date: _____

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## MEDICAL HISTORY



First Name: _____ Last Name: _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been instructed to take pre-medication prior to dental treatment? _____

| Do You Have or Have You Ever Had: | YES | NO |
|---|---|---|
| 1. hospitalization for illness or injury | ☐ | ☐ |
| 2. an allergic reaction to: | ☐ | ☐ |
| ☐ aspirin, ibuprofen, acetaminophen, codeine | | |
| ☐ penicillin | | |
| ☐ erythromycin | | |
| ☐ tetracycline | | |
| ☐ sulfalocal | | |
| ☐ anesthetic | | |
| ☐ fluoride | | |
| ☐ metals (nickel, gold, silver, _____) | | |
| ☐ latex | | |
| ☐ other _____ | | |
| 3. heart problems, or cardiac stent within the last six months _____ | ☐ | ☐ |
| 4. history of infective endocarditis _____ | ☐ | ☐ |
| 5. artificial heart valve, repaired heart defect (PFO) ____ | ☐ | ☐ |
| 6. pacemaker or implantable defibrillator_____ | ☐ | ☐ |
| 7. orthopedic implant (joint replacement) _____ | ☐ | ☐ |
| 8. rheumatic or scarlet fever _____ | ☐ | ☐ |
| 9. high or low blood pressure _____ | ☐ | ☐ |
| 10. a stroke (taking blood thinners)_____ | ☐ | ☐ |
| 11. anemia or other blood disorder_____ | ☐ | ☐ |
| 12. prolonged bleeding due to a slight cut (INR > 3.5) _ | ☐ | ☐ |
| 13. emphysema, shortness of breath, sarcoidosis _____ | ☐ | ☐ |
| 14. tuberculosis, measles, chicken pox_____ | ☐ | ☐ |
| 15. asthma _____ | ☐ | ☐ |
| 16. breathing or sleep problems_____ (i.e. sleep apnea, snoring, sinus) | ☐ | ☐ |
| 17. kidney disease _____ | ☐ | ☐ |
| 18. liver disease _____ | ☐ | ☐ |
| 19. jaundice_____ | ☐ | ☐ |
| 20. thyroid, parathyroid disease, or calcium deficiency | ☐ | ☐ |
| 21. hormone deficiency _____ | ☐ | ☐ |
| 22. high cholesterol or taking statin drugs _____ | ☐ | ☐ |
| 23. diabetes (HbA1c =_____) _____ | ☐ | ☐ |
| 24. stomach or duodenal ulcer _____ | ☐ | ☐ |
| 25. digestive disorders _____ (i.e. celiac disease, gastric reflux) | ☐ | ☐ |
| 26. osteoporosis/osteopenia_____ (i.e. taking bisphosphonates) | ☐ | ☐ |
| 27. arthritis_____ | ☐ | ☐ |
| 28. autoimmune disease_____ (i.e. rheumatoid arthritis, lupus, scleroderma) | ☐ | ☐ |
| 29. glaucoma _____ | ☐ | ☐ |
| 30. contact lenses_____ | ☐ | ☐ |
| 31. head or neck injuries _____ | ☐ | ☐ |
| 32. epilepsy, convulsions (seizures) _____ | ☐ | ☐ |
| 33. neurologic disorders _____ (ADD/ADHD, prion disease) | ☐ | ☐ |
| 34. viral infections and cold sores _____ | ☐ | ☐ |
| 35. any lumps or swelling in the mouth _____ | ☐ | ☐ |
| 36. hives, skin rash, hay fever _____ | ☐ | ☐ |
| 37. STI / STD / HPV _____ | ☐ | ☐ |
| 38. hepatitis (type _____) _____ | ☐ | ☐ |
| 39. HIV / AIDS _____ | ☐ | ☐ |
| 40. tumor, abnormal growth _____ | ☐ | ☐ |
| 41. radiation therapy _____ | ☐ | ☐ |
| 42. biphosphonates _____ | ☐ | ☐ |
| 43. chemotherapy, immunosuppressive medication____ | ☐ | ☐ |

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| | YES | NO |
|---|---|---|
| 44. emotional difficulties | ☐ | ☐ |
| 45. psychiatric treatment | ☐ | ☐ |
| 46. antidepressant medication | ☐ | ☐ |
| 47. alcohol / recreational drug use | ☐ | ☐ |

**Are You:**

| | | |
|---|---|---|
| 48. presently being treated for any other illness | ☐ | ☐ |
| 49. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) | ☐ | ☐ |
| 50. taking dietary supplements | ☐ | ☐ |
| 51. often exhausted or fatigued | ☐ | ☐ |
| 52. experiencing frequent headaches | ☐ | ☐ |
| 53. a smoker, smoked previously or use smokeless tobacco | ☐ | ☐ |
| 54. taking birth control pills | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| 55. currently pregnant | ☐ | ☐ |
| 56. prostate disorders | ☐ | ☐ |

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections).

**List all medications, supplements, and or vitamins taken within the last two years.**

*Please advise us in the future of any change in your medical history or any medications you may be taking.*

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

**ASA _____ (1-6)**

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