SEYCOVE DENTAL
getting deep cove healthier since 1974

WELCOME TO SEYCOVE DENTAL

NEW PATIENT FORM

www.seycovedental.com 604.929.5022 info.seycovedental.com

LAST NAME | FIRST NAME | MIDDLE INTIAL | GENDER ☐ MALE ☐ FEMALE

NICKNAME | DATE OF BIRTH | EMAIL

ADDRESS | CITY/PROVINCE | POSTAL CODE

(H) PHONE | (M) PHONE | (W) PHONE | OCCUPATION/EMPLOYER

EMERGENCY CONTACT NAME | PHONE

WHOM DO WE THANK FOR REFERRING YOU?

☐ OTHER ☐ GOOGLE/INTERNET ☐ WALK BY ☐ POSTCARD DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO

PREFER: ☐ TEXT ☐ EMAIL ARE YOU AVAILABLE ON SHORT NOTICE? ☐ YES ☐ NO

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist | Reason for Leaving

Date of most recent dental exam | Date of most recent x-rays | I routinely see a dentist every: ☐ 3 mo. ☐ 4mo. ☐ Gmo. ☐ 12mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN?

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
1. Are you fearful of dental treatment or had an unfavourable dental experience?	☐	☐
2. Have you ever had complications from past dental treatment?	☐	☐
3. Have you ever had trouble getting numb, reactions to local anesthetic?	☐	☐
4. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Would you consider orthodontic treatment for your teeth?	☐	☐
7. Do you I would you have any problems chewing gum or hard foods, such as a bagel?	☐	☐
8. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)?	☐	☐
9. Do you have headaches, sore teeth (eg. during sleep) or any problems chewing hard foods?	☐	☐
10. Do you grind or clench your teeth?	☐	☐
11. Do you wear or have ever worn a grinding/clenching appliance (eg. night guard)?	☐	☐
12. Do you wear or have you ever worn any other dental appliances {eg. dentures, retainers)?	☐	☐
13. Have you had any cavities within the past 3 years?	☐	☐
14. Do you have a dry mouth?	☐	☐
15. Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
16. Have you ever been diagnosed or treated for periodontal (gum) disease or recession?	☐	☐
17. Do your gums bleed when brushing, flossing or eating?	☐	☐
18. Are your teeth becoming loose?	☐	☐
19. Have you ever had any oral or periodontal (gum) surgery?	☐	☐
20. Are you interested in closing any spaces between your teeth or replacing any missing teeth?	☐	☐
21. Do you snore loudly or has anyone observed you stop breathing during your sleep?	☐	☐
22. Do you often feel tired, fatigued or sleepy during the daytime?	☐	☐
23. What is your current daily oral hygiene regimen?	☐	☐

MEDICAL HISTORY

Patient Name

Name of Physician

Physician Phone number

Reason for most recent physical examination:

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO		YES	NO
Hospitalization for illness or injury			Stomach, duodenal ulcer or digestive disorder		
An allergic reaction to:			Diabetes Type		
-Aspirin, ibuprofen, acetaminophen			Osteoporosis/penia (eg taking bisphosphonates)		
-Penicillin / Amoxicillin			Arthritis		
- Erythromycin / Tetracycline			Head or neck injuries		
- Codeine			Epilepsy, convulsions (seizures)		
- Local anesthetic			Neurologic problems		
-Metals (gold, stainless steel)			Viral infections or cold sores		
- Latex			Any lumps or swelling in the mouth		
-Any other:			Hives, skin rash, hay fever		
Heart problems / Heart murmur			Hepatitis (type)		
High cholesterol			HIV/AIDS		
Rheumatic fever / Scarlet fever			Tumour, abnormal growth, cancer		
High or low blood pressure			adiation therapy / Chemotherapy		
Stroke			Emotional problems / Psychiatric treatment		
Artificial prosthesis (i.e. heart valve or joints)			Antidepressant medication		
Anemia or other blood disorder			Alcohol / drug dependency		
Prolonged bleeding due to a small cut			Presently being treated for any other illness		
Asthma / Emphysema / Tuberculosis			A smoker or smoked previously		
Breathing or sleep problems (ie snoring, sinus)			FEMALE - taking birth control pills		
Kidney disease			FEMALE- pregnant Y N Due date:		
Liver disease			FEMALE- breast feeding		
Thyroid or parathyroid disease			MALE prostate disorders		
Hormone deficiency					

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

LIST ALL MEDICATIONS, SUPPLEMENTS, AND OR VITAMINS TAKEN WITHIN THE LAST YEAR:

Drug	Purpose	Drug	Purpose

PERMISSION FOR TREATMENT

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics as indicated, and I will assume responsibility for fees associated with those procedures. If for any reason the insurance company does not pay the full amount for the treatment rendered, I am responsible for the balance.

Signature

Date

Patient Parent Guardiano