KINGSTON WEST DENTAL CENTRE
Dr. Michael A. Van Buren

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New Patient Health History Questionnaire

Mr./Miss/Mrs./Ms./Dr. Patient name _____ _____

Surname Given Names Preferred name

Address (Home)

_____ PostalCode _____

Phone number(s) _____ _____ _____

Home Cell Work

E-mail _____ Date of Birth: (D/M/Y) _____

Employer _____

Preferred contact method: □ Phone □ E-mail □ Text Message (please note, we will only use email or text for appointment confirmation, scheduling, or an accounting/financial matter)

DENTAL INSURANCE INFORMATION

Please complete this section if you have a dental insurance plan
(Name, address, date of birth, phone number and employer for person responsible for account if different than you, _____

Name, address, date of birth, phone number and employer for person with primary and/or secondary insurance if *different* than you, _____

Primary Insurance Plan Co _____ Secondary Insurance Co. _____

Plan Number _____ Plan Number _____

Subscriber ID/Certificate No. _____ Subscriber ID/ Certificate No. _____

MEDICAL HISTORY

In case of emergency, whom should we contact? Please include name, their relationship to you, and the best phone number to contact them.

_____

Please provide the name and contact information for your medical doctor(s) – general practitioners and specialists

_____

When was your last medical examination?

_____

What pharmacy do you generally use? _____

Are you being treated for any medical condition at present or within the past year? If yes, please explain.

_____

Do you have any allergies? If you answered yes, please list using the categories below:

a) medications b) latex/rubber products c)other (e.g. hay fever, foods)

Medical Alert- Do you/should you wear a medical alert bracelet? Y or N, If yes, what for?

Please list any medications, non-prescription drugs, inhalers, or herbal supplements that you are taking.

Have you ever had a peculiar or adverse reaction to any medication or injections? If yes, Please explain.

Do you or have you ever smoked or chewed tobacco products? How much and how often?

Do you have, or have you ever had cancer? Did you undergo chemotherapy or radiation to the head and neck region?

Have you ever been advised by your doctor to take antibiotics before dental treatment?

Do you have a bleeding problem or bleeding disorder?

Do you have any conditions or therapies that could affect your immune system?

Are there any diseases or medical problems that run in your family? Y or N? If yes, please list,

Do you have or have you ever had any of the following? Please check.

□ ADD/ADHD	□ Antibiotics prior to dental visits	□ Arthritis	□ Asthma
□ Autism	□ Bacterial Endocarditis	□ Cancer	□ Cold Sores
□ Congestive heart failure		□ Diabetes	□ Drug/alcohol dependency
□ Depression/anxiety		□ Epilepsy/Seizures	
□ Gastric Reflux	□ Heart Attack	□ Heart Murmur	□ Heart Valve Replacement
□ Hepatitis	□ Liver Disease	□ HIV/AIDS	□ High blood pressure
□ Leukemia	□ Kidney Disease	□ Lung Disease	□ Osteoporosis medications
□ Pacemaker	□ Rheumatic fever	□ Organ transplant	□ Radiation Therapy
□ Sinus Issues	□ Sleep Apnea	□ Steroid therapy	□ Stomach Ulcers
□ TB	□ Thyroid Disease	□ Mitral Valve Prolapse	□ Prosthetic or Artificial Joint

Are there any conditions or diseases not listed above that you have or have had? □ Y or □ N If so what?

Do you sleep well? _____

Do you breathe through your mouth while awake or asleep? _____

Do you snore? _____ Do you clench or grind your teeth while awake or asleep? _____

Have you ever had a sleep study? □Y or□No? If yes, when? _____

Women Only: Are you pregnant?□Y or□N , If yes, when is your expected delivery date? _____

Women only: Are you breastfeeding? □Y or□N

DENTAL HISTORY

What brings you to our office? Do you have any immediate dental concerns?

_____

When was your last dental visit and what was done? _____

When were your most recent dental radiographs (x-rays) taken? _____

I routinely saw my dentist every□3 months□6 months□9 months□12 months□Not routinely

How nervous are you about dental treatment on a scale of 1 (low) to 10 (high)? _____

Have you ever had an unfavorable dental experience or complications as a result of dental treatment? Please explain: _____

Are there any growths or sore spots in your mouth? _____

Have you noticed any loose teeth or have any of your teeth shifted? _____

Does food get caught between your teeth? _____

Are any of your teeth sensitive to heat, cold, sweets or pressure? _____

How often do you use dental floss? _____

How often do you brush your teeth? _____ Do you feel that you have bad breath? _____

Have you ever had any of the following? Please check

□Orthodontic treatment (straighten teeth) □Periodontal surgery (treatment of gums) □Biteplate

□Your bite adjusted or teeth reshaped □Oral surgery (surgery in or about the mouth/jaw joint) □Night guard

Do you have any of the following jaw problems? Please check □Popping/clicking □Pain in your jaw joints

□Difficulty opening or closing mouth □Pain/difficulty chewing □Pain with clenched teeth

Please indicate any concerns or conditions that apply to you:

□Bleeding Gums □Biting your teeth or lips regularly □Difficulty with freezing □Dry Mouth

□Gag Reflex □Gum Recession □Nail Biting or other habits □Orthodontics

□Periodontal disease (gum disease) □Sensitivity

Are you happy with the appearance of your teeth? If not, what would you change? _____

_____

Are you interested in having any amalgam (silver/mercury) fillings replaced with bonded composite resin (white) fillings? _____

Do you have any other questions or concerns relating to your dental treatment that have not yet been addressed?

_____

STOP BANG QUESTIONNAIRE

(Answer yes or no for each question by circling the correct answer)

S (snore) Do you snore? **Y** **N**

T (tired) Do you feel fatigue during the day? Y N Do you wake up feeling like you haven't slept? **Y** **N**

O (obstruction) Have you been told you stop breathing at night? **Y** **N**

P (pressure) Do you have high blood pressure or are you on medication to control high blood pressure? **Y** **N**

SCORE: If you checked YES to two or more questions on the STOP portion, you are at risk for OSA (obstructive sleep apnea)

B (BMI) Is your body mass index greater than 28? Height: _____ Weight: _____ **Y** **N**

USC Units:

$$\text{BMI} = 703\text{x} \frac{\text{mass (lbs)}}{height^2 \text{(in)}}$$

SI, Metric Units:

$$\text{BMI} = \frac{\text{mass (kg)}}{height^2 \text{(m)}}$$

A (age) are you 50 years or older? **Y** **N**

N (neck) Are you a male with a neck circumference >17 inches, or a female with a neck circumference of >16 inches? **Y** **N**

G (gender) Are you male? **Y** **N**

SCORE: the more questions you checked YES to on the BANG portion, the **greater your risk** of having moderate to severe OSA.

Patient Release I, the undersigned, certify that I have provided an accurate and complete medical and dental history and not knowingly omitted any information. I authorize the dentist to preform diagnostic procedures and treatment as may be necessary for proper dental care.

Patient/Parent/Guardian Signature _____ Date _____

Witness Signature _____ Date _____

FINANCIAL POLICIES

Please remember, **patients are responsible for all fees charged** by this office regardless of insurance coverage. For patients with dental Insurance, there may be a portion of the fee that is not covered by your plan, this is referred to as the co-payment.

We do our best to help you understand your insurance plan, but are not your plan administrator and not responsible for prescribed treatment being covered. Treatment is prescribed based on your oral health needs not on insurance limitations. Payment for services not covered by insurance is due at the time service is rendered unless arrangements have been made in advance.

If the co-payment cannot be determined at the time of service, the claim is held by the insurance carrier or the claim has to be sent by mail, the balance owing will be estimated and collected based on your coverage and collected.

We also request that a credit card # be placed on your file. Balances if any, will be processed as soon as the we receive payment from your insurance company. We will email you a copy of the receipt and EOB upon completion of the transaction.

For your convenience we accept Visa, MasterCard, Cash and Debit

It is your responsibility to notify us of all changes or updates to your contact information or dental plan (new plan, terminated plan, change in benefit amounts, post-secondary student status of children (full/part-time).

Missed/Short notice cancellation policy: without 2 working days' (Monday -Thursday) notice for all booked appointments, we reserve the right to bill your account a $50 fee which is to be paid prior to rebooking the appointment.

I have reviewed, understand and accept the practice policies. _____ (Initial please)

Authorization for the Electronic Claims Submission and Assignment of Benefits

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Michael Van Buren/Kingston West Dental Centre and authorize payment directly to him or KWDC. This authorization shall continue in effect until the undersigned revokes the same.

Patient/Parent/Guardian Signature _____ Date(D/M/Y) _____

I authorize release, to my benefits plan administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. Van Buren and Kingston West Dental Centre

This authorization shall continue in effect until the undersigned revokes the same.

Patient/Parent/Guardian Signature _____ Date(D/M/Y) _____

Express Consent to Email and Text Correspondence

I have reviewed to practice polices pertaining to email and text message correspondence with KWDC.

□ Yes, I consent to receive emails from Kingston West Dental Centre

E-mail: _____

□ No thank you. I wish to opt out of future emails from Kingston West Dental Centre

□ Yes, I consent to receive text messages from Kingston West Dental Centre regarding myself and/or family.

Cell: _____

□ No thank you. I wish to opt out of future text messages from Kingston West Dental Centre

Patient/Parent/Guardian Signature _____ Date(D/M/Y) _____

PATIENT CONSENT FORM: COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I have reviewed the Collections, Use and Disclosure of Personal Health Information Patient Consent form set forth by the RCDSO, that explains how your office will use personal health information, and the steps your office is taking to protect my information.

I agree that Dr. Michael Van Buren/Kingston West Dental Centre can collect, use and disclose my personal health information for myself or the aforementioned family members as set out above in the information about the office's privacy policies.

Dated this _____ day of _____, 20_____.

_____ _____

Patient Signature (Legal Guardian) Witness Signature

Name:_____ Name:_____

(please print) (please print)