



141 – 2401G Millstream Rd. Victoria, BC, 250-474-4742 www.orchiddental.ca

3. CONDITIONS

Please circle if you have ever had any of the following diseases or medical conditions.

- Alzheimer's / Memory Loss
- Anemia
- Anorexia / Bulimia
- Arthritis
- Artificial Joints (Date _____)
- Artificial Heart Valves
- Asthma / Hay Fever
- Blood Transfusions
- Cancer / Chemotherapy
- Cold Sores / Herpes
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug / Alcohol Abuse
- Emphysema
- Epilepsy / Seizures / Fainting
- Gastrointestinal Disorder / Acid Reflux
- Glaucoma (Narrow Angle)
- Headaches (Severe, Frequent)
- Hearing Impaired
- Heart Attack
- Heart Murmur
- Heart Surgery
- Hemophilia / Abnormal Bleeding
- Hepatitis A B C D
- High / Low Blood Pressure
- HIV / AIDS
- Liver Disease
- Kidney Problems
- Mitral Valve Prolapse
- Pacemaker
- Radiation Treatments
- Rheumatic / Scarlet Fever
- Shingles
- Smoking / Tobacco
- Sinus Problems
- Stents Placed in Heart (Date _____)
- Stroke
- Snoring / Sleep Apnea
- Tuberculosis
- Tumor Growth
- Venereal Disease
- Other / Surgeries

New Patient Form

Patient Name: _____ Date of Birth: Month _____ Day _____ Yr _____

Address: _____ Postal Code _____

Home Phone: _____ Cell: _____ email: _____

Date of Last Dental Visit _____

Insurance Company: _____ Policy ID#: _____

Policy Holder Name: _____ Group#: _____

Policy Holder Date of Birth: _____ Employer of Policy Holder: _____

Employer Phone Number: _____ 2nd insurance policy? Y/N

How did you hear of us? _____

1. HEALTH HISTORY

Today's Date _____

Personal Physician _____

Clinic-Location _____

Phone No. _____

Please list any medications you are currently taking (include over the counter medicines)

Medications	Reasons

Are you currently taking birth control pills? Yes No

Have you ever taken osteoporosis treatment drugs? Yes No

2. ALLERGIES

Please circle if you have any allergies to the following:

- | | | | | |
|-----------------------|---------|--------------|------------------|--------------|
| Amoxicillin | Aspirin | Erythromycin | Metals / Jewelry | Sulfa |
| Anesthetics | Codeine | Latex | Penicillin | Tetracycline |
| Other (explain) _____ | | | | |

(If any circled) please describe symptoms: _____

DENTAL CONCERNS:	

Have you ever been told you need antibiotics before a dentist appointment? Yes No

Are you pregnant? Yes No

Are you currently nursing? Yes No

Would you like to speak privately with the Doctor about any problems?

Yes No

I hereby certify that the information given here is correct to the best of my knowledge.

Signature of Patient (or Parent or Guardian): _____ Date: _____

Submit this form to our staff at your convenience.

ORCHID DENTAL Office Policies

Thank you for choosing our practice for your dental care and oral health needs.

Our policies are intended to help provide you with quality dental care and personalized attention. For your safety, please inform us of any changes in your health or prescribed medications before your visit.

As a courtesy to our clients we accept assignment from your insurance carrier and will bill directly to them for you. Payment for your portion is due at the time of treatment. For procedures involving a laboratory component, a deposit will be required when treatment is started. We offer payment by Visa, Mastercard, American Express, Debit and Cash for your convenience.

We are an amalgam-free office and use tooth-coloured ('white') composite filling material for direct restorations. Some insurance carriers will not cover the cost of "white fillings" and will pay the amount charged for amalgam. If this happens you are responsible to pay the difference which will depend on the extent of the filling required.

We accept most dental plans and we will utilize the plan to maximize your benefits. However, we prefer to prescribe the best dental treatment for each client regardless of the participation of the dental plan. We encourage you to be completely familiar with the terms of your dental insurance plan. This is a contract between you and your dental insurance. With your approval, predetermination of insurance benefits can be obtained in advance from your insurance company by our office. The amount settled by the insurance company may be affected by such factors as annual limits of coverage, non-coverage procedures, etc. Each company carries a different plan and this makes it extremely difficult for us to be aware of each and every plan detail. We will do our best to assist you with your plan when at all possible, but it is important to understand that you are ultimately responsible for payment of any treatment.

If you find that you are unable to keep your scheduled appointment, we require **two business days** notice so that we may accommodate the dental needs of other patients. A charge of \$50 Per hour of dental hygienist's time and \$100 per hour of dentist's time will be applied to your account if we do not receive 2 business days notice to change your appointment time.

Your signature below indicates that you have read and understood the above and are aware of the policies in our office.

Name (print)

Signature

Date