orchid DENTAL

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

New Patient Form

How did you hear of us?_____

Patient Name:_____ Date of Birth: Month_____Day_____Yr_____

Address: _____Postal Code_____ _____

Home Phone: ____-____-_____ Cell: ____-____-_____ Gender _____

email: _____

Approx Time Since Last Dental Visit _____

1st Ins. Co: _____Policy ID#: _____

Policy Holder Name: _____Group#:_____

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

Employer Phone Number: _____

NOTES: _____

2nd Ins. Co.: _____ Policy ID:_____

Policy Holder Name:_____ Group #:_____

Policy Holder Date of Birth: _____Employer of Policy Holder:_____

Emergency Contact Name: _____ ***Emerg contact Phone:*** ____ - ____ - _____

1. HEALTH HISTORY

Personal Physician

Clinic-Location

Phone No.

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

Medications	Reasons

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:	

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 Date:_____
Cancer / Chemotherapy
Cold Sores / Herpes
Congenital Heart Defect Date:_____
Diabetes Type: I / II
Difficulty Breathing
Drug / Alcohol Abuse
Emphysema
Epilepsy / Seizures / Fainting
Gastrointestinal Disorder / Acid Reflux
Glaucoma (Narrow Angle)
Headaches (Severe, Frequent)
Hearing Impaired
Heart Attack Date:_____
Heart Murmur
Heart Surgery Date:_____
Hemophilia / Abnormal Bleeding
Hepatitis A B C D
High / Low Blood Pressure
HIV / AIDS
Liver Disease
Kidney Problems
Shingles
Smoking / Tobacco
Sinus Problems
Stents Placed in Heart (Date_____)
Stroke Date:_____
Snoring / Sleep Apnea
Tuberculosis
Tumor Growth
Venereal Disease
Other / Surgeries

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:** _____

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 $80 per hour of dental hygienist's time and $160 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. These fees set in 2023 and will be subject to change with inflation.

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