Viceroy Dental Clinic- 606 Belmont Street, New Westminster, BC V3M 0G9
604-522-2558, viceroydental@shaw.ca

NEW PATIENT INTAKE FORM

Name _____ _____ _____ Date _____
first middle last
Gender: Male / Female / Other Birth Date _____
day/month/year
Marital Status: Single/Married/Widowed/Common-Law/Divorced/Separated
Address: Apt _____ Street _____ City _____ Prov _____
Postal _____
Phone: (Home) _____ (Cell) _____ (Work) _____
Email: _____
How do you prefer to be contacted: Email ☐ Text ☐ Phone ☐

Insurance:

Primary Insurance
Insurance Provider _____ Group/Policy Number _____
Certificate/Member ID _____ Employer Name _____
Policyholder's Name _____ Policyholder's Birthdate _____
Relationship of Patient to Policyholder: Self ☐ Spouse ☐ Child ☐ Other ☐
Do you have secondary insurance? Yes ☐ No ☐

Secondary Insurance
Insurance Provider _____ Group/Policy Number _____
Certificate/Member ID _____ Employer Name _____
Policyholder's Name _____ Policyholder's Birthdate _____
Relationship of Patient to Policyholder: Self ☐ Spouse ☐ Child ☐ Other ☐

Dental History:

Date of Last Visit _____ Reason for Last Visit _____
Name of Previous Dentist/Dental Clinic _____
Date of Last X-Rays _____
What is your reason to visit today? _____
Do you have any concerns about your dental health? Yes ☐ No ☐ If yes, please explain
_____
Do you clench or grind your teeth? Yes ☐ No ☐
Do your gums bleed when you brush or floss your teeth? Yes ☐ No ☐
Do you notice any sensitivity to hot, cold, or pressure when you eat or drink? Yes ☐ No ☐
Do you take a premedication prior to any dental treatment? Yes ☐ No ☐
Do you notice if food gets stuck in or between your teeth? Yes ☐ No ☐
Do you gag easily during prior dental treatment? Yes ☐ No ☐
Are you apprehensive about dental treatment? Yes ☐ No ☐
Is there anything you would change about your smile? Yes ☐ No ☐
If so, what do you think would help improve it?
_____

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Do you snore or have sleep problems? Yes ☐ No ☐
Do you have headaches? Yes ☐ No ☐
Do you have fatigue? Yes ☐ No ☐

Medical History:

Do you have any allergies to the following:

Aspirin	☐	Ibuprofen	☐	Acetaminophen	☐
Penicillin	☐	Latex	☐	Codeine	☐
Sulfa	☐	Erythromycin	☐	Local Anesthetic	☐
Metals	☐	Other: _____			

Have you ever had or currently have any of the following medical conditions (check those that apply):

AIDS	☐	Cancer	☐	Anemia	☐	Arthritis	☐
Artificial Joints	☐	Asthma	☐	Blood Disease	☐	Diabetes	☐
Chemotherapy	☐	Dizziness	☐	Addictions	☐	Emphysema	☐
Excessive Bleeding	☐	Fainting	☐	Glaucoma	☐	Heart Conditions	☐
Head/Neck Injury	☐	Headaches	☐	Hepatitis A	☐	Hepatitis B	☐
Hepatitis C	☐	High Blood Pressure	☐	HIV	☐	HPV	☐
Jaundice	☐	TMJ	☐	Kidney Disease	☐	Liver Disease	☐
Low Blood Pressure	☐	Depression	☐	Eating Disorder	☐	Hearing Problems	☐
Mental Disorders	☐	Viral Infections	☐	Cold Sores	☐	Respiratory Problems	☐
Hives	☐	Hay Fever	☐	Pacemaker	☐	Pregnancy	☐
Rheumatic Fever	☐	Rheumatism	☐	Seizures	☐		
Sleep Apnea	☐	Stroke	☐	Digestive Problems	☐		
Tuberculosis	☐	Ulcers	☐	Thyroid Disease	☐		

Any other health conditions that are not listed, or any that need to be explained further:

_____
_____
_____

Are you currently taking any medications/supplements/vitamins? Please list them below:

_____
_____
_____
_____
_____

How did you hear about our clinic?
Another Patient ☐ Who?_____ Walk-By ☐
Online ☐ Where? _____ Other ☐_____

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Authorization/Consent for Services

I authorize the diagnosis of my dental healthy by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the payment from my insurance carrier to submit payment directly to the dentist/dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

I certify that I have read, understood, and accurately completed the personal, medical, and dental histories to the best of my knowledge and have not knowingly omitted any information. If required, I consent to my physician being contacted regarding any specific medical question.

I agree that Viceroy Dental Clinic has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information.

Date _____ Signature _____