

PERSONAL INFORMATION

DATE _____

NAME _____ BIRTHDATE D ___ M ___ Y ___

ADDRESS _____

_____ MARITAL STATUS ___ SEX ___

POSTAL CODE _____ TEL: HM _____ WORK _____ CELL _____

E-MAIL _____ PARENT/GUARDIAN (IF UNDER 18 YRS) _____

OCCUPATION _____ EMPLOYER _____

PHYSICIAN _____ PHONE _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE? _____

INSURANCE INFORMATION

DO YOU HAVE INSURANCE? NO YES

PERSONAL HEALTH NUMBER _____

INSURANCE HOLDER _____ DOB _____

INSURANCE COMPANY _____ GROUP NUMBER _____

CERTIFICATE NUMBER _____ EMPLOYER _____

DEPENDENT# _____ BASIC COVERAGE _____ % MAJOR COVERAGE _____ % ORTHO _____ %

2nd INSURANCE HOLDER _____ DOB _____

INSURANCE COMPANY _____ GROUP NUMBER _____

CERTIFICATE NUMBER _____ EMPLOYER _____

DEPENDENT# _____ BASIC COVERAGE _____ % MAJOR COVERAGE _____ % ORTHO _____ %

****HEALTH ALERTS** (FOR OFFICE USE ONLY)**

OFFICE POLICY

This has been written at the recommendation of the College of Dental Surgeons of British Columbia. Our intent is to clarify our office policies with you to help eliminate misunderstandings. Thank you.

FEES This office bases its fees on the current BC College of Dental Surgeons fee guide. All professional services must be paid for at the time the services are performed by cash, personal cheque, Visa, Mastercard, or Debit.

MEDICAL CONDITIONS It is very important that you notify us with changes in your health, including conditions, medications etc. Failure to advise us could result in serious consequences.

APPOINTMENT RESPONSIBILITIES Patients wishing to cancel or change an appointment **MUST GIVE 48 HOURS NOTICE** otherwise the patient will be charged for professional time lost. Please notice that once you have made an appointment, this time is reserved for you.

INSURANCE PLANS We will submit claims to your insurance company directly, however, any differences between the fee amount charged for your treatment and the amount paid by your plan is the your responsibility.

COMPLETE UPDATED INSURANCE INFORMATION MUST BE SUPPLIED BY THE PATIENT or the full fee will be charged to you directly.

Please note that the insurance plan is a contract between you, the employer, and the insurance companies. Ongoing changes with insurance plans makes it is impossible for our office to know exactly what your plans do/do not cover. Dental insurance companies do not inform the dental office of changes to your plan. Also, some companies have their own fee schedules, exclusions, and maximum amounts they pay for a particular treatment.

We would be pleased to assist you in understanding your plan coverage based on the information you provide us. Upon request we can provide you with an **ESTIMATE** of the fees for treatment required as well as an **ESTIMATE** of what the insurance company will pay based on the current information you provide us.

In the event that the insurance company sends you direct payment, this must be forwarded to our office directly. Otherwise, the complete treatment fee will be billed to you directly for payment in full.

DEPOSITS With all extensive treatment such as crowns, bridges, denture (full and partial) and appliances ½ of the fee must be paid at the initial appointment and the balance at the time of insertion.

If extenuating circumstances develop, please advise the dentist prior to commencement of treatment so that suitable arrangements can be made.

I, _____ do hereby authorize the performance of oral diagnostic, oral rehabilitation, and oral surgery procedures agreed to be necessary or advisable by Dr. Ikonomou, including the use of local anesthetic or other drugs indicated. I further agree to notify the dentist of any changes in medical status. I certify that I have read and fully understand the above, and agree to comply with these conditions. I also understand that if these conditions are not upheld Dr. Ikonomou may choose to end the patient/dentist relationship.

I, _____ herby authorize the release of dental information contained in the claims to be submitted electronically to my insurance plan administrator, and I herby authorize direct payment to Dr. Ikonomou for benefits from these claims submitted electronically.

Signature of Patient/Guardian

Date

MEDICAL HISTORY

The following is required to thoroughly diagnose any condition and to give the highest possible standard of professional service. Although some questions may seem unimportant at the moment, they may be vital in case of emergency and possible drug interactions. Therefore PLEASE ANSWER EVERY QUESTION. Please feel free to ask the receptionist for help when completing this form. All information will be kept strictly confidential.

Please **CIRCLE** YES or NO. If YES, fill in all details.

1. Date of last complete **Medical** exam and blood studies _____
2. Are you under the care of a physician now or in the last 2 years? _____ YES NO
3. Have you had a serious illness or surgery? _____ YES NO
4. Have you ever been hospitalized? _____ YES NO
5. Have you taken steroids (cortisone) within the past 2 years? _____ YES NO
6. Are you taking medications for osteoporosis, low bone density, or treatment of bone cancer? _____ YES NO
7. Have you taken any medications, drugs, pills in the past 6 months? _____ YES NO
Please list _____
8. Have you had treatment with chemo, surgery, or radiation for a tumor or growth? _____ YES NO
8. Are you pregnant? _____ YES NO
9. Are you taking oral contraception? _____ YES NO
10. Have you ever had hay fever, hives, or skin rash? _____ YES NO
11. Have you experience any unusual reaction to local dental anaesthetics? _____ YES NO
Provide details _____
12. Are you allergic to or have reacted adversely to any of the following? *please circle*
Aspirin Codiene Iodine Sedatives Barbituates(sleeping pills)
Penicillin Other Antibiotics Sulpha Others: _____
13. Do you have or have you had:
 - A) Rheumatic fever or rheumatic heart disease _____ YES NO
 - B) Heart attack _____ YES NO
 - C) Heart trouble (palpitations, rapid beat, arrhythmia) _____ YES NO
 - D) High or low blood pressure _____ YES NO
 - E) Congenital heart defect _____ YES NO
 - F) Heart murmur _____ YES NO
 - G) Chest pains upon exertion _____ YES NO
 - H) Shortness of breath after mild exercise _____ YES NO
 - I) Swelling of ankles _____ YES NO
 - J) Asthma _____ YES NO
 - K) Tuberculosis _____ YES NO
 - L) Chronic bronchitis or emphysema _____ YES NO
 - M) Prolonged bleeding with simple cuts _____ YES NO
 - N) Frequent nose bleeds _____ YES NO
 - O) Abnormal bleeding with previous surgery, extraction, or accident _____ YES NO
 - P) Blood transfusion _____ YES NO
 - Q) Tendency to bruise easy _____ YES NO

- R) Family history of bleeding _____ YES NO
- S) Any blood disorder such as anaemia _____ YES NO
14. Do you have or have you had any of the following?
- a. Hepatitis, jaundice or liver disease _____ YES NO
 - b. Stomach ulcer _____ YES NO
 - c. Gall bladder, bladder, or kidney problem _____ YES NO
 - d. Any Venereal diseases _____ YES NO
 - e. Are you in a risk category for HIV? _____ YES NO
15. Have you had an injury to you head, face, or jaws? _____ YES NO
16. Do you suffer from frequent headaches? _____ YES NO
17. Do you have eye problems (glaucoma)? _____ YES NO
18. Do you have sinus trouble or nasal congestion? _____ YES NO
19. Any foods you cannot eat? _____ YES NO
20. Have you ever had a stroke? _____ YES NO
21. Do you have a tendency to faint or have dizziness? _____ YES NO
22. Have you ever had convulsions or seizures? _____ YES NO
23. Have you had numbness or tingling in any part of your body? _____ YES NO
24. Have you ever been treated for mental illness? _____ YES NO
25. Do you suffer from arthritis? _____ YES NO
26. Have you had joint replacement surgery? _____ YES NO
27. Has your weight changed more than 10lbs in the past 6 months? _____ YES NO
28. Do you have diabetes? _____ YES NO
- a. Do you experience discomfort in a warm room? _____ YES NO
 - b. Are you thirsty much of the time? _____ YES NO
 - c. Do you urinate more than 6 times per day? _____ YES NO
29. Do you heal slowly or have frequent infections? _____ YES NO
30. Have you had or do you have thyroid or parathyroid disease? _____ YES NO
31. Do you smoke cigarettes? How many per day? _____ YES NO
32. Do you drink alcohol? How much per week? _____ YES NO
33. Do you use recreational or medical cannabis? Type and frequency. _____ YES NO
34. Do you have a disease or condition not listed above? _____ YES NO

Chief dental complaint

Do you have any dental concerns? Please provide details.
