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)**

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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. (Women) Are you pregnant?_____ YES NO
9. (Women) 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 anesthics?_____ 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 AIDS? 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 or nervous disease? 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? How many? YES NO
32. Do you consistently use alcoholic beverages? YES NO
33. Do you have a disease or condition not listed above? YES NO

Chief dental complaint

Do you have any dental concerns? Please provide details.

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DENTAL HISTORY

1. Last dental appt?_____ Past frequency of visits._____ Last cleaning._____
2. Is any part of your mouth sensitive to temperature, pressure?_____ YES NO
   Where?_____
3. Have you had signs of periodontal disease(please circle)? Bleeding gums
   Swelling gums Gum ache Receding gums Loose teeth Drifting teeth
4. Does food catch between your teeth? If so where?_____ YES NO
5. Do you have frequent cold sores or canker sores?_____ YES NO
6. Do you have difficulty swallowing?_____ YES NO
7. Do you have a burning sensation in your mouth?_____ YES NO
8. Do you have an unpleasant odor in your mouth?_____ YES NO
9. How often do you brush?_____ Floss?_____
10. Have you had the following treatments? Root canal Crowns Bridges
    Orthodontics(braces) Periodontal (gums) Tooth removal (extractions) Extraction
    Full/partial dentures Implants Bleaching Other:_____

TMJ SCREENING

1. Do you have habits such as (please circle): clenching grinding lip biting
   mouth breathing tongue thrusting cheek biting
2. Do you wake up with the awareness of your teeth or jaws? How often?_____ YES NO
3. Do you have difficulty opening your mouth widely?_____ YES NO
4. Are you aware of stiff neck muscles?_____ YES NO
5. Do you have tension headaches?_____ YES NO
6. Do you have sore jaw muscles?_____ YES NO
7. Any clicking or popping jaw joint sounds?_____ YES NO
8. Pain in front of your ears when chewing, or during yawning speaking?_____ YES NO
9. Have you ever had problems with your ears (ringing, change of hearing)?_____ YES NO
10. Have you noticed your bite changing or space between your teeth?_____ YES NO
11. Have you ever had a night guard/splint?_____ YES NO

MEDICAL UPDATES (Office use only)

DATE UPDATE

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