RIVIERA DENTAL CLINIC

101 – 629 LANDSDOWNE STREET
KAMLOOPS, BC, V2C 1Y6
250-314-1234

Personal Information

First & Last Name: _____ Preferred Name:_____
CareCard (Pers. Health #):_____ Date of Birth: MM ___ DD ___ YR____
Address:_____ Gender: _____
Postal Code: _____
Email Address: _____
Home phone: _____ Cell phone: _____ Other phone: _____
Preferred Method of Contact ? ☐ Email ☐ Text ☐ Phone
I authorize contact from Riviera Dental Office here via email or text? YES NO

Who may we thank for referring you? _____

Insurance – Primary (if applicable)

Policyholder Name: _____ Policyholder's Birthdate: MM ___ DD ___ YR_____
Insurance Carrier: _____ Employer: _____
Policy/Group #:_____ Insured ID/Certificate #_____

Insurance - Secondary (if applicable)

Policyholder Name: _____ Policyholder's Birthdate: MM ___DD ___ YR_____
Insurance Carrier: _____ Employer: _____
Policy/Group #:_____ Insured ID/Certificate #:_____

I authorize Dental Office Here to submit claims electronically on my behalf. I assign my benefits and authorize payment directly to Riviera Dental Clinic ☐NO ☐YES

Dental History

1. Name of Previous Dentist: _____
2. When was your last dental visit? _____
3. When did you last have dental x-rays? _____
4. How often do you brush your teeth? 1x day 2x day 3x day
5. Do you use manual toothbrush or electric toothbrush? ☐ Manual ☐ Electric
6. How often you floss your teeth? _____
7. List any other oral hygiene measures you utilize: (e.g. rinses, waterpik)
   _____
8. Do your gums bleed when you brush? N Y If so where? _____
9. Do you have any pain when you chew? N Y If so where? _____
10. Do you grind or clench your teeth? N Y
11. Do you feel you have bad breath? N Y
12. Have you ever had orthodontic (braces) treatment? N Y
13. Have you ever had a negative reaction to dental anesthetic? N Y
    If yes, please explain. _____
14. Do you have sensitive teeth? N Y
15. Please list anything else not listed above regarding your dental history_____
    _____

Please Turn Over

Medical History

The following information is required to enable us to provide you with the best possible dental care. All information is strictly confidential. We will review the questions and explain any you do not understand. Please fill in the entire form.

1. Name of Physician:_____ Phone #: _____
2. Emergency Contact person: _____ Phone #_____
   Relationship _____
3. Drug Allergies/sensitivities? _____
4. Are you taking any medications, non-prescriptive drugs, herbal supplements, or street drugs of any kind? Please list: _____
   _____
5. Your current health is: Excellent: _____ Good: _____ Fair: _____ Poor: _____
6. Have you been hospitalized in the past 2 years? N Y
   If yes, please explain_____
7. Have you ever been advised to take antibiotics prior to dental work for a heart murmur, mitral valve prolapse, rheumatic fever or artificial joint? N Y
   Please Specify: _____
8. List any medical conditions you are currently being treated for: _____
   _____
9. Do you have or have you ever had (Please Circle):
   Aids Anxiety Asthma Arthritis Auto-immune disorder Blood disorder Cancer Diabetes Depression Epilepsy Heart issues Herpes Hepatitis High blood pressure HIV Jaundice Liver disease Lung disease Kidney disease Pacemaker Psychiatric Treatment Osteoporosis Stroke Substance abuse issues Tuberculosis Thyroid disease Ulcers Other_____
10. Do you smoke? Y N If yes, how many per day or week? _____
11. Women Only – Are you pregnant? Y N Due Date: _____

Consent to Treatment and Office Policies

1. I authorize the doctor, upon consultation and direct consent from the patient/parent/guardian to perform diagnostic procedures, treatment, x-rays and medication in the connection with the patient's dental needs.
2. I understand that the responsibility for payment of dental services, including insurance or otherwise, is due and payable at the time of services rendered and despite any dental insurance and I am ultimately responsible for any fees withheld by the insurance company.
3. I agree to provide 48 business hours' notice if I have to cancel or reschedule my appointments in order to avoid any fees.

To the best of my knowledge, all of the preceding answers are true and correct. If there are any changes I agree to inform Riviera Dental Clinic at my next appointment.

_____ _____

Signature (Patient/Parent/Guardian) Date