Dr. Doug Sims, D.M.D.

Our goal is to provide superior dental care for the quality conscious patient in a caring and comfortable environment.

PERSONAL INFORMATION

To help us serve you as quickly and accurately as possible, please provide us with the following information:

Name _____

(given) (initial) (surname)

How would you like to be addressed in our office? _____

Address _____

_____

(city) (province) (postal code)

Phone: (Home) _____ (Work) _____ (Fax) _____

(Cell) _____ (Pager) _____ (E-mail)_____

Is it okay to call you at your business? □ Yes □ No

Is it okay to call you on your cell phone? □ Yes □ No

Are you available at short notice? □ Yes □ No

Where and when are the best times to contact you? _____

_____

When is it most convenient for you to schedule your appointments? _____

_____

Date of birth _____ Sex □ Male □ Female □

Occupation _____ Employer _____

Do you have dental insurance benefits? □ No □ Yes **-please present your benefit card and booklet**

Are you self employed with your own company? □ Yes □ No

Next of kin _____ Phone number _____

Person responsible for account _____ Phone number _____

Whom should we thank for referring you to our office? _____

To help us provide you with the most effective treatment and reduce the chance of unnecessary complication, please take a moment to answer the following questions as accurately as you can.

MEDICAL HISTORY

Name of your physician _____

Date of last physical examination_____

Are you taking any drugs or medications? □ Yes □ No

Drug _____ Reason _____

Drug _____ Reason _____

Drug _____ Reason _____

Do you take aspirin regularly? □ Yes □ No

Do you have an allergic reaction to LATEX products or kiwi fruit? □ Yes □ No

Are you allergic to any drugs or medications? □ Yes □ No List _____

Do you smoke? □ Yes □ No How much per day?_____

Alcohol use □ Yes □ No Non-prescription drugs? □ Yes □ No

Do you have a nervous or psychiatric disorder? (explain) _____

Women: Pregnant □ Yes □ No Taking birth control pills □ Yes □ No

Do you now have or have you ever had:

Yes	No		Yes	No	
□	□	Rheumatic fever	□	□	Kidney disease
□	□	High blood pressure	□	□	Muscle/ joint disorders(e.g.arthritis)
□	□	Heart murmur	□	□	Cancer, radiation therapy
□	□	Asthma or allergies	□	□	Lung problems (e.g. emphysema)
□	□	Diabetes	□	□	Prolonged bleeding
□	□	Glaucoma	□	□	Hepatitis A____ B____ C ____
□	□	Tuberculosis	□	□	Liver disease
□	□	Pacemaker	□	□	Aids or tested HIV Positive
□	□	Sensitivity / Allergy to latex	□	□	Eating disorder
□	□	Serious accident or whiplash	□	□	Hip or joint replacement
□	□	Heart disease, heart attack, angina	□	□	Artificial heart valves, organ transplant

Have you ever had an unfavourable reaction or allergy to local anaesthetic (freezing)? (please describe)_____

Any other conditions or problems not previously listed? (please describe) _____

_____

Medical Carecard # _____

DENTAL HISTORY

We take the responsibility of caring for your oral health very seriously. The following is a series of questions that will help us tailor dental treatment to suit your dental needs and desires. As well, this information will assist us in providing quality treatment in the most comfortable manner possible.

When was your last dental visit? _____Name of dentist seen_____
How frequently did you see your last dentist? _____
When did you last have a full set (16-20) of x-rays? _____
Do you smoke or use any tobacco products? □ Yes □ No
Do you ever have bad breath? □ Yes □ No
Are you having any emergency dental problems? ____Describe_____
Do any of the following cause tooth discomfort? Hot □ Cold □ Sweet □ Chewing □
How often do you brush your teeth? _____ Floss? _____ Other? _____
Do your gums bleed when cleaning? ____Describe_____
Have you ever had periodontal (gum) treatment? ____ When? _____
What kind of treatment? _____
Do you clench or grind your teeth? ___ When? _____
Do your jaws ever feel tired or ache? _____ Click or pop? _____
Can you chew on both sides of your mouth? ___ Comfortably? _____
Do you have frequent headaches? _____ Earaches? _____
Have you ever had orthodontic treatment (braces)? ___ When? _____
Do you ever have fillings break or fall out? _____
Do you usually have cavities or decay at check-ups? _____
If you need any teeth fixed, which is important to you: Strength □ Appearance □ Both □
Do you have any loose teeth? _____ Cracked or broken teeth? _____
Do you have any noticeable wear on any teeth? _____
Do you have an area where food gets caught? ____ Describe _____
Do you have any missing teeth? _____ Have they been replaced? _____
If so, how? Fixed bridge _____Removable denture _____Implant _____
Are you comfortable with the replacement? ____ Why? _____
How do you feel about the appearance of your smile? _____
Have you had any cosmetic dentistry done to change your appearance? _____
How do you feel about the results?_____
Have you ever had an unpleasant dental experience? ____Please describe _____
_____
How would you rate the condition of your mouth? Excellent 5 4 3 2 1 Please help!
If you could change anything you wanted about your mouth, what would it be? _____

PAYMENT OPTIONS

□ Cash / Cheque / Debit

□ Visa Account # _____ expiry___/___ VCode:____

□ MasterCard Account # _____ expiry___/___VCode:____

Cardholder _____ X_____

DENTAL INSURANCE INFORMATION

Primary Policy Holder
Name _____Employer _____
Date of Birth_____ Insurance Carrier_____
Plan/Group #_____ Certificate/ID #_____
Dependent # (Pacific Blue Cross only) _____

Details of primary coverage:
Deductible $_____ Annual maximum $_____ Basic (A) _____% Major (B) _____%
Plan uses current BC College Fee Guide □ Yes □ No / other: ____(year) _____(province)
Check-up every: (circle one) 6 9 12 months
Hygiene/perio benefit _____units/$ / per _____ months
Plan covers tooth coloured (white) fillings on molars □ Yes □ No
*Please provide us with your Insurance ID member card and policy booklet.

Secondary Policy Holder
Name _____Employer _____
Date of Birth_____ Insurance Carrier_____
Plan/Group #_____ Certificate/ID #_____
Dependent # (Pacific Blue Cross only) _____

Details of secondary coverage:
Deductible $_____ Annual maximum $_____ Basic (A) _____% Major (B) _____%
Plan uses current BC College Fee Guide □ Yes □ No / other: ____(year) _____(province)
Check-up every: (circle one) 6 9 12 months
Hygiene/perio benefit _____units/$ / per _____ months
Plan covers tooth coloured (white) fillings on molars □ Yes □ No
*Please provide us with your Insurance ID member card and policy booklet.

DENTAL INSURANCE IS DESIGNED TO ASSIST PLAN MEMBERS WITH BASIC TREATMENT USING THE LEAST EXPENSIVE METHODS AND MATERIALS POSSIBLE; IT IS NOT INTENDED TO COVER EVERYTHING. WE DO NOT DISCRIMINATE AGAINST THOSE WITH INSURANCE BENEFITS BY OFFERING A LESSER QUALITY TREATMENT.

X_____ _____