WELCOME!

Your cooperation in completing this questionnaire is essential to providing you with comprehensive dental care. All information is strictly confidential.
If you need assistance, please ask our receptionist.

Dr. Glenn Vandepeear Inc.
RIVER CITY DENTAL
www.rivercitydental.ca

Please Print. Thank you!

Name ____________ Date of Birth M D Y Sex ____

Address Street City Province Postal Code

( ) Home Phone | Email | ( ) Cell Phone | ( ) Work Phone

Employer/Occupation ____________ May we call you at work? ____

Referrals are important to us. Who may we thank for referring you to our office? ____________

Family Physician ____________ Phone ( )

Emergency Contact/Parent ____________ Phone ( )

PRIMARY DENTAL INSURANCE

Subscriber's Name ____________

Employer ____________

Ins. ____________ D.O.B. ____

ID/SIN ____________ Group # ____

Coverage:

Basic % C&B % Dent./Ortho % Deductible ____

Financial Limit ____ Recall Frequency ____

SECONDARY DENTAL INSURANCE

Subscriber's Name ____________

Employer ____________

Ins. Co. ____________ D.O.B. ____

ID/SIN ____________ Group # ____

Coverage:

Basic % C&B % Dent./Ortho % Deductible ____

Financial Limit ____ Recall Frequency ____

Is there a dental problem you would like treated immediately? Y N **If yes, please describe:**

____

Date of last dental visit: ____________ Date of last dental cleaning :____________

May we request x-rays/records from your previous dentist? If yes, please name your previous dentist below:

____

	YES	NO
1. Have you been seeing a dentist regularly? …………	☐	☐
2. Do your gums bleed when brushing or eating?…………	☐	☐
3. Are any of your teeth sensitive to heat, cold, sweets or pressure? …………	☐	☐
4. Have you been advised to take antibiotics before a dental appointment? …………	☐	☐
5. Do you have problems with your jaw joint (pain, clicking, locking)? …………	☐	☐
6. Do you clench or grind your teeth in the day/night? …………	☐	☐
7. Are you unhappy with the appearance of your teeth? …………	☐	☐
What would you like to see changed? ____________		
8. Have you ever had an upsetting experience at a dental office, any complications during or following dental treatment or have any questions or concerns? …………	☐	☐

MEDICAL HISTORY

	YES	NO
1. Have you had any serious illnesses in the past 5 years that required medical treatment?…………………	☐	☐
If yes, please specify ______________________________		
2. Are you currently under a physician's care, or taking any medication?...	☐	☐
If yes, please specify ______________________________		
3. Do you have any allergies or sensitivities to any drugs such as penicillin, novocaine, aspirin or codeine?...	☐	☐
If yes, please specify ______________________________		
4. Have you ever been advised against taking any specific medications?...	☐	☐
5. Do you bleed excessively after a cut, wound or surgery? ………………………………………………..	☐	☐
6. Do you take any health supplements? (Vitamins/Herbs)………………………………………………….	☐	☐

7. Please indicate which of the following you currently have or have ever had:

	YES	NO		YES	NO		YES	NO
A.I.D.S.	☐	☐	Glaucoma	☐	☐	Liver disease	☐	☐
Anemia	☐	☐	Head/neck injuries	☐	☐	Lung disease	☐	☐
Angina	☐	☐	Heart disease/attack	☐	☐	Mental/nervous disorder	☐	☐
Arthritis/rheumatism	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart pacemaker	☐	☐	Organ transplant/implant	☐	☐
Artificial joints (hip, knee)	☐	☐	Heart rhythm disorder	☐	☐	Psychiatric treatment	☐	☐
Asthma	☐	☐	Heart surgery	☐	☐	Radiation/chemotherapy	☐	☐
Blood disorders	☐	☐	Hepatitis A	☐	☐	Rheumatic fever	☐	☐
Bronchitis	☐	☐	Hepatitis B	☐	☐	Sinus trouble	☐	☐
Cancer	☐	☐	Hepatitis C	☐	☐	Smoking	☐	☐
Circulation problems	☐	☐	Hepatitis __________	☐	☐	Stomach/intestinal prob.	☐	☐
Congenital heart lesions	☐	☐	High/Low blood pressure	☐	☐	Stroke	☐	☐
Cortisone/steroid	☐	☐	H.I.V.	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Hodgkin's disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Hyper/Hypo Glycemia	☐	☐	Ulcers	☐	☐
Epilepsy or seizures	☐	☐	Hypertension	☐	☐	Venereal disease	☐	☐
Fainting or dizzy spells	☐	☐	Jaundice	☐	☐	Other _______________	☐	☐
Glandular disorder	☐	☐	Kidney disease	☐	☐	Other _______________	☐	☐

8. Are you pregnant or suspect you may be? [Y] [N]   If yes, what is your expected due date? ________________

Office Policies...for full practice information please visit *www.rivercitydental.ca* or ask our receptionist

APPOINTMENTS:
We request that you provide at least **2 business days** notice for appointments you must cancel. We will gladly reschedule your appointment. Please note that we must charge a fee for missed appointments for which we have not received adequate notice.

FINANCIAL:
Payment for dental services is due at the time dental services are provided.
For patients with dental insurance, our office will send a claim for the dental service provided to your Insurance Company on your behalf. It is your responsibility to provide us with your current and accurate insurance coverage. We do not accept responsibility for amounts not covered by individual insurance plans. Payment of the patient percentage (if applicable) is due at the time services are provided.

Signature: ______________________________ **Date:** ______________________________