Viva
Dental Studio

New Patient Intake Form

Cancellation Requirement: Appointment times are booked exclusively for you, therefore 48 business hours' notice is required for any change or cancellation.

Personal Information:

Name: _____ DOB: _____ ❑ M ❑ F ❑ Married ❑ Single ❑ Other
Address: _____ Postal Code: _____
Hospitalization # _____
Phone #: (Home) _____ (Work) _____ (Cell) _____
Email Address: _____ (receipts will be emailed.)
Employer: _____ Position: _____
Dental Insurance: Yes / No (please circle)
Emergency Contact: _____ Phone #: _____
Name of spouse/parent (if under 18): _____
How did you hear of our office? _____

Dental Insurance:

Primary
Insurance company name: _____ Group #: _____
Certificate #: _____ Div #: _____
Name of policy holder: _____ DOB: _____
Yearly maximum: _____

Secondary
Insurance company name: _____ Group #: _____
Certificate #: _____ Div #: _____
Name of policy holder: _____ DOB: _____
Yearly maximum: _____

Supplementary Health Benefits: Yes / No (please circle if applicable).

First Canadian Health: Yes / No (please circle if applicable). **Status number**: _____

Dental History:

Reason for today's visit: _____ Previous dentist: _____
Date of last check-up/cleaning: _____ How often do you brush? _____
Floss? _____ Are you nervous about dental treatment? Yes / No (please circle)
Have you ever had any complications with previous dental treatment? Yes / No
(If yes: _____)

Are you having any concerns at this time? Yes / No (If yes _____)
Are you satisfied with how your teeth look? Yes / No _____
Are you interested in whitening your smile? Yes / No

Do you ever experience any of the following?

❑ Bad Breath ❑ Sore gums ❑ Bleeding Gums ❑ Clicking or popping jaw ❑ Space/Crooked teeth
❑ Grinding Teeth ❑ Missing Teeth ❑ Broken fillings ❑ Sensitive teeth ❑ Headaches ❑ Neck Pain
❑ Strong Gag Reflex ❑ Loose Teeth

Medical History

Are you currently in good health? Yes / No (if no) _____
Do you smoke or chew tobacco? Yes / No
Are you taking any type of medication at time? Yes / No (if yes please list them) _____
_____

WOMEN ONLY
Are you pregnant? Yes / No (If yes, due date) _____ Are you currently nursing? Yes / No
Birth control pill? Yes / No

Have you ever had any of the following diseases or medical problems?
❑ Heart Problems ❑ Chest pain ❑ Heart murmur ❑ High/low blood pressure ❑ Rheumatic fever ❑ Scarlet Fever ❑ Ulcers ❑ Arthritis ❑ Stroke ❑ Artificial joints ❑ Kidney problems ❑ Diabetes (type 1 or 2) ❑ Thyroid problems ❑ Glaucoma ❑ Emphysema ❑ Cancer
❑ Tuberculosis ❑ Swollen ankles ❑ Psychiatric disorder ❑ Hemophilia ❑ Liver disease
❑ Difficulty breathing ❑ Neurological disorders ❑ Drug/alcohol abuse ❑ Asthma Hay Fever
❑ Sinus Problems ❑ Bruise easily ❑ Chemotherapy ❑ Hepatitis A B C (please circle)
❑ Venereal disease ❑ AIDS/HIV positive ❑ Fetal alcohol syndrome ❑ Abnormal bleeding
❑ Fainting/dizzy spells ❑ Nervous/anxious ❑ Epilepsy/seizures
Anything else that was not listed: _____

Are you allergic to any of the following?
❑ Local anesthetic ❑ Codeine ❑ Penicillin or other antibiotics ❑ Sulfa drugs ❑ Any metals
❑ Barbiturates ❑ Latex rubber ❑ Iodine ❑ Any other not listed: _____

I hereby consent to allow all necessary dental procedures and services to be performed. This may include x-rays and or dental freezing. I understand there are limitations with certain procedures and in some instances, complications may occur. I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If I ever have changes in my health I will inform the Dr. at my next appointment without fail.

Signature of patient or guardian: _____ **Date:** _____