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**Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal code\_\_\_\_\_\_\_\_\_\_\_

Birthdate DD\_\_\_\_\_\_\_\_\_\_ MM\_\_\_\_\_\_\_YY\_\_\_\_\_\_\_ Care Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Name (if under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emerg. Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recommended by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to be set up for automatic appointment reminders? **YES NO** **TEXT** or **EMAIL**

**Dental Insurance Additional coverage**

Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***HOW DO YOU FEEL ABOUT YOUR SMILE?***

Would you like your teeth whiter? **Yes No** Do you think your teeth are too crooked? **Yes No**

Are you concerned with stains on your teeth? **Yes No** Do you have missing teeth you want replaced? **Yes No**

I would like more information on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF LAST DENTAL EXAM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ANY PREVIOUS MAJOR TREATMENT? **Yes No** WHEN? \_\_\_\_\_\_\_\_\_\_\_

NAME OF PREVIOUS DENTIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW OFTEN DO YOU VISIT THE DENTIST? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ANY DENTAL CONCERNS AT PRESENT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING?***

***(Check which apply)***

\_\_\_Teeth sensitive to cold, hot, sweets or pressure \_\_\_Use an electric tooth brush

\_\_\_Bleeding gums. How long? \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Food impaction area

\_\_\_Bad Breath \_\_\_Unpleasant Taste

\_\_\_Oral habits, i.e., fingernail biting, cheek biting \_\_\_Mouth breathing

\_\_\_Smoking/Vape/chewing tobacco \_\_\_TMJ concerns

\_\_\_Clenching/grinding habit \_\_\_Use mouthwash or fluoride rinse

\_\_\_Do you snore/difficulty breathing/sleeping \_\_\_Use a CPAP machine while sleeping

\_\_\_Feel tired/fatigued, or sleepy during the day \_\_\_Ever told you stop breathing while you sleep

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**Medical History**

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a medical exam in the past year? **YES NO**

Are you being treated for any condition by a physician now? **YES NO** If yes; what: \_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever reacted adversely to any of the following? (Please circle all that apply)

**Aspirin Penicillin Iodine Barbiturates Fluoride Local Anaesthetic**

**Codeine Sulfa drugs Latex Ibuprofen Acetaminophen**

Do you have any other allergies? **YES NO**  Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had or do you have any of the following conditions?

**Please underline and list beside any medications, if applicable, currently prescribed for the following conditions:**

**STD’s\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis A B C or Jaundice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Kidney disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High/Low Blood pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Anemia/Blood disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Arthritis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Artificial Heart valve \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mitral valve prolapse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Artificial Joint replacement\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organ transplant/medical device\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer/Radiation/Chemotherapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mental/Nervous disorder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rheumatic fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sores on lips on mouth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cholesterol\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes- Type l – ll\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Stomach/Intestinal problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Epilepsy/Seizers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TB/Lung disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardiovascular disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid disease (Hyper/Hypo) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ADHD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fainting/dizzy spells\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hard of Hearing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other medications or conditions not listed above or further details:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you bruise or bleed abnormally? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**YES NO**

Have you ever had any injury, surgery or radiation on your face or jaws? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**YES NO**

Are you on any special diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**YES NO**

Are there any genetically linked disorders in your family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **YES NO**

Do you currently have, or have had in the past, any disease, condition or problem not listed above? If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Women only:**

Are you pregnant or suspect you may be? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **YES NO**

Are you taking birth control pills? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**YES NO**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Print **Name** Patient **Signature**

Monashee Dental Centre

*Dr. Paula Winsor-Lee & Dr. Remy Winklmeier*

 (250) 547-2104

 2000 Norris Ave, Lumby, BC, V0E 2G0

 mdcsmile@telus.net

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome to Monashee Dental! Thank you for selecting our office for your dental care. We are committed to providing excellent dental care with concern for your personal needs. The following information will acquaint you with our office financial policies and allow us to provide a high quality of service to you.

* ***Our Financial Policy***

FULL PAYMENT is due at the time of service, unless we are billing your insurance for you, in which case any applicable co-payment or deductible is due at time of service. If payment is not received at time of service, a 10% service fee will be added. \_\_\_\_\_\_\_\_**initial**

* ***Regarding Insurance***

As a courtesy we will bill your benefit plan for the charges which the company has agreed to pay. We appreciate the opportunity to help you maximize your dental benefits to which you may have access. In order to provide you the best information on your plan we will need to know the details of your benefits, and any services provided outside of our office. Pre-authorizations are known to change. If your benefit plan has not paid your account in 60 days, the balance becomes your responsibility and will become due immediately. Please be aware that not all products or services provided are approved for payment by your benefit plan, but have been deemed to be in your best interest by your dentist.

* ***Missed Appointments***

For the courtesy of other patients that are waiting for appointment times, please be aware that we require 2 business days notice to change or cancel an appointment to avoid a $50.00/hour fee. If a true emergency should arise the policy will be re-evaluated on a case-by-case basis. \_\_\_\_\_\_\_\_**initial**

* ***Responsibility***

If you are over 18 years old you are legally responsible for your own account regardless of who you come with, who has a benefit plan or claims you as a tax deduction. If the patient is under 18 years of age, both parents despite divorce or other separating arrangements, or the legal guardian of the patient is responsible for payment. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made; this ensures that we can provide the essential treatment in an informed manner. It is the authorizing parent’s responsibility to collect from the other parent if necessary.

 ***CONSENT FOR CARE:***

I request the consultation services of Dr. Paula Winsor-Lee or Dr. Remy Winklmeier. I authorize the doctor to take any necessary x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of treatment needs. I understand this may include consultation with my physician or other practice specialists. I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

I have read the Financial Policy and understand and agree to its terms:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Print **Name** Patient **Signature**