Today's Date: _____

Patient Intake Form

Appointment Date/Time: _____

Name: _____

Date of Birth: _____

Care Card #: _____

Address: _____

No Fixed Address: ☐ _____

Phone: _____

Alternate #/Email: _____

Contact Agency/Person: _____

In pain? Yes ☐ No ☐ On Waitlist: Yes ☐ No ☐

Last Dental Visit: _____

Who referred you?: _____

Main Concern: _____

Financial Assessment Completed: Yes ☐ No ☐ Approved: Yes ☐ No ☐

Insurance Plan: MSD ☐ Social Services H Kids ☐ Premium Assistance Disability ☐ PWD NIHB ☐ First Nations DVA ☐ Veteran Affairs

Insurance Carrier: _____

Group # _____ ID # _____ Dep # _____

_____% Basic _____% Major

Insurance Limitations: _____

Eaglesoft Medical History(NEW)(Copy)2018(Copy)(Copy)(Copy)(Copy)(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Do you use Marijuana	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug/Alcohol Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No	Cancer ◯ Yes ◯ No
Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No	Chemotherapy ◯ Yes ◯ No
Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No	Chest Pains ◯ Yes ◯ No
Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No	Cold Sores/Fever Blisters ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No	Congenital Heart Disorder ◯ Yes ◯ No
Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No	Convulsions ◯ Yes ◯ No
Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Adult Mental Health ◯ Yes ◯ No

Do you have, or have you had, any of the following?

Anxiety Disorder	◯ Yes ◯ No
ADHD/ADD	◯ Yes ◯ No
Bipolar Disorder	◯ Yes ◯ No
Depression	◯ Yes ◯ No
Eating Disorders	◯ Yes ◯ No
Obsessive-Compulsive Disorder	◯ Yes ◯ No
Opioid Use Disorder Symptoms	◯ Yes ◯ No
Panic Disorder	◯ Yes ◯ No
Postpartum Depression	◯ Yes ◯ No
Posttraumatic Disorder (PTSD)	◯ Yes ◯ No
Schizophrenia	◯ Yes ◯ No
Sesonal Affective Disorder (SAD)	◯ Yes ◯ No
Social Anxiety Phobia	◯ Yes ◯ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Consent for Dental Treatment & Release of Information

Applicant's Name:_____

Family Doctor:_____ **Walk-in Clinic you attend:**_____

Dr's Phone#_____

The purpose of this consent is to help you understand there are risks that can occur during dental procedures. The dentist and staff will take steps to limit these risks.

Risks associated with dental procedures may include:

- Soreness in teeth or gums
- Infection or prolonged bleeding(not common)
- Muscle or joint soreness caused by holding your mouth open for a long time
- Drug or chemical reactions caused by dental materials and medications(not common)
- Long-term numbness from dental frezzing and extractions(not common)

I consent to dental treatments as explained by the dentist and staff at the Kelowna Gospel Mission Dental Clinic and I understand that all treatments and procedures have a risk.

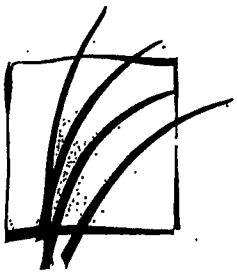
I consent to release and exchange of information between my physician and/or medical clinic, government, pharmacist, insurance carrier, and/or social agencies and the Kelowna Gospel Mission Dental Clinic staff to facilitate my dental care.

Patient/Guardian Signature_____

Date:_____

Reviewed by: _____

[redacted]



Kelowna's
Gospel Mission

I, _____ agree to the following as a patient at the Kelowna Gospel Mission Dental Clinic.

- All parties are to be treated with Kindness and Respect. We do not tolerate abusive, foul language or actions. That will be an automatic dismissal from our office.
- To be responsible for keeping all scheduled appointments.
- Any cancellations and changes to appointments require a minimum notice of 24 hours in advance.
- To be on time for appointments. After 15 minutes late for an appointment, you will not be seen and need to rebook. This is considered a "missed" appointment.
- After 3 missed or late appointments you will be asked to find another dental office for treatment.

Signature _____ Date_____

Witness_____