Dental Clinic
Kelowna
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 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: _____

# Consent for Dental Treatment and Release of Information

Applicant's Name: _____

Family Doctor: _____

Walk-in Clinic you attend: _____

Doctor's Phone Number: _____

The purpose of this consent is to help you understand that 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 freezing 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 the 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.

Parent/ Guardian Signature: _____

Date: _____

Reviewed by: _____

# COVID-19 Screening Checklist Extended

Please sign below each statement to indicate you agree:

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I knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

I understand the novel coronavirus causes the disease known as COVID-19 and that it has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I acknowledge and understand that dental procedures create water spray which is one way that the novel coronavirus can spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus.

I understand that due to the frequency of visits of other dental patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in a dental office.

I have been made aware of the College of Dental Surgeons of British Columbia guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of ongoing tissue bleeding, alleviate severe pain or infection or conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3 to 6 months.

I confirm I am seeking treatment for a condition that meets these criteria.

I confirm that I am not currently positive for the novel coronavirus.

I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus.

I verify that I have not returned from any country outside of Canada in the past fourteen (14) days.

I understand that Public Health has asked individuals to maintain social distancing of at least 2 metres (6 feet) and it is not possible to maintain this distance and receive dental treatment.

I verify that I have not been identified as a contact of someone who has tested positive for COVID-19 or been asked to self-isolate by Public Health

Please turn page →

Do you have any of the following symptoms of COVID-19? Please circle yes or no.

| | |
|---|---|
| Fever > 38 °C | YES/NO |
| Cough | YES/NO |
| Sore Throat | YES/NO |
| Shortness of Breath | YES/NO |
| Flu-Like Symptoms | YES/NO |

I confirm that I am not presenting symptoms of COVID-19. Please sign below

I verify the information I have provided on this form is truthful and accurate. I knowingly and willingly consent to have the emergency dental treatment completed during the COVID-19 pandemic.
Please sign below:

Please turn page →

# Existing Patient Medical/Dental History

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## DENTAL INFORMATION – Please Circle Yes or No (provide additional info if necessary)

| | |
|---|---|
| Do your gums bleed while brushing or flossing? | YES/NO |
| Do you bite your lips or cheeks frequently? | YES/NO |
| Have you ever had Orthodontic (braces) Treatments? | YES/NO |
| Do you have Headaches or Migraines? | YES/NO |
| Are your teeth sensitive to cold, hot, sweets or pressure? | YES/NO |
| Have you had any difficult extractions in the past? | YES/NO |
| Do you feel pain to any of your teeth? | YES/NO |
| Ever worn a bite plate or other appliance? | YES/NO |
| Do you have any sores or lumps in or near your mouth? | YES/NO |
| Have you ever had difficulty opening or closing jaw? | YES/NO |
| Have you ever had a head, neck or jaw injury? | YES/NO |
| Have you had any pain in your jaw area? | YES/NO |
| Do you have any loose teeth or have they ever shifted? | YES/NO |
| Have you ever had Periodontal Treatment (gums)? | YES/NO |

Please give a brief description of your Oral Hygiene habits:

If you have a current dental problem, please describe:

## MEDICAL INFORMATION

Are you currently seeing a Family Physician? YES/NO
If so, please enter name, phone number, and date of last visit.:

Have you recently (in the last two years) been hospitalized or had a major operation? YES/NO
Please Explain.:

Have you ever taken any medications containing Fosamax, Boniva, Actonel or any other medications containing bisphosphonate? YES/NO
If yes please list the name of the ones you took and when you took them:

Please list any prescription or non-prescription medicine you are currently taking or have recently taken:

Date of your last Physical Exam:

Are you or could you be pregnant? YES/NO
If yes, what is the expected delivery date?
Taking Birth control pills? YES/NO

Do you use any form of Tobacco or are wearing a nicotine patch? YES/NO
Do you use any controlled substances or street drugs? YES/NO If Yes please describe.

Please turn page →

Do you have any of the following medical conditions? Please circle YES/NO

AIDS/HIV Positive: YES/NO
Chest Pains: YES/NO
Cortisone Medication: YES/NO
Hemophilia: YES/NO
Alzheimer's Disease: YES/NO
Circulation Problems: YES/NO
Hepatitis A: YES/NO
Diabetes: YES/NO
Hepatitis A: YES/NO
Hepatitis B or C: YES/NO
Anemia: YES/NO
Emphysema: YES/NO
High Blood Pressure: YES/NO
Low Blood Pressure: YES/NO
Arthritis/Gout: YES/NO
Epilepsy/Seizures: YES/NO
Kidney Problems: YES/NO
Artificial Heart Valve: YES/NO
Congenital Heart Disease: YES/NO
Mitral Valve Prolapse: YES/NO
Fainting: YES/NO
Liver Disease: YES/NO
Artificial Joint: YES/NO
Glaucoma: YES/NO
Lung Disease: YES/NO
Asthma: YES/NO
Head or Neck injuries: YES/NO
Mental/Nervous Disorder: YES/NO
Blood Disease: YES/NO
Heart Attack/Failure: YES/NO
Organ/Medical Transplant: YES/NO
Bruise Easily: YES/NO
Heart Murmur: YES/NO
Sickle Cell Disease: YES/NO
Cancer: YES/NO
Heart Pace Maker: YES/NO
Stroke: YES/NO
Chemotherapy: YES/NO
Radiation Treatment: YES/NO
Heart Surgery: YES/NO
Tuberculosis: YES/NO
Osteoporosis: YES/NO
Thyroid Disease : YES/NO
Parathyroid Disease: YES/NO
Psychiatric Care: YES/NO
Renal Dialysis: YES/NO
Rheumatic Fever: YES/NO
Rheumatism: YES/NO
Scarlet Fever: YES/NO
Shingles: YES/NO
Sickle Cell Disease: YES/NO
Sinus trouble: YES/NO
Spina Bifida: YES/NO

Please enter any other details or other conditions you may have not listed above:

Do you have any of the following conditions? Please circle YES/NO
Anxiety Disorder: YES/NO
ADHD/ADD: YES/NO
Bipolar Disorder: YES/NO
Depression: YES/NO
Eating Disorders: YES/NO
Obsessive Compulsive Disorder: YES/NO
Panic Disorder: YES/NO
Postpartum Depression: YES/NO
Posttraumatic Stress Disorder (PTSD): YES/NO
Schizophrenia: YES/NO
Seasonal Affective Disorder: YES/NO
Social Anxiety Phobia: YES/NO

Please list any allergies below, this can include asthma, hay fever, food allergies, and metal or latex allergies.:

Are you allergic to or have you had a reaction to any of the following medications?
Barbiturates, sedatives or sleeping pills: YES/NO
Antibiotics: YES/NO
Aspirin: YES/NO
Codeine: YES/NO
Local Anesthetic: YES/NO

Please sign below indicating all of the above information is correct to the best of your knowledge:

Patient Signature:

Please turn page →

Date: _____

# Patient Intake Form

Appointment Date/ Time: _____

Name: _____

Date of Birth: _____

Care Card # _____

Address: _____

Phone: _____

Alternate #/ Email: _____

Contact Agency/ Person: _____

In pain? Yes ☐ No ☐

Last Dental Visit: _____

Who referred you? _____

Main Concern: _____

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

Insurance Plan: MSD Services ☐ H Kids Premium Assistance ☐ Disability PWD ☐

NIHB First Nations ☐ DVA Veteran Affairs ☐