New Patient Form

VALLEY DENTAL STUDIO

1316 Main St E.
Swan River, MB R0L 1Z0
Ph: 204-614-1444 Fax: 204-614-1445
admin@valleydentalstudio.com

DATE:_____/_____/_____
Day Month Year

Patient Information

Name:_____
First Middle Last

☐ male
☐ female

Pronouns:
☐ she/her
☐ he/him
☐ they/them
☐ other _____

Date of Birth:_____/_____/_____ PHIN #:_____ - _____ - _____
Day Month Year

Mailing Address:_____ Street Address:_____

City:_____ Province:_____ Postal Code:_____

Primary Phone :_____ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER

Secondary Phone:_____ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER

Other Phone: _____ ☐ HOME ☐ MOBILE ☐ WORK ☐ SPOUSE ☐ CAREGIVER

E-mail address:_____

Emergency Contact:_____ Relation:_____ Phone #:_____

FNIHB # (if applicable): _____

PRIMARY INSURANCE:

Insurance Carrier: _____
Policy/Group #:_____
Subscriber Name: _____
Subscriber date of birth: _____
Certificate #:_____

SECONDARY INSURANCE (IF APPLICABLE):

Insurance Carrier: _____
Policy/Group #:_____
Subscriber Name: _____
Subscriber date of birth: _____
Certificate #:_____

Family Physician:_____ Clinic/Address: _____

Pharmacy used:_____

Date of first appointment: _____

How did you hear about Valley Dental Studio? _____

Why did you come to Valley Dental Studio? _____

Please list any medical conditions or chronic illnesses (eg. Diabetes):

_____

_____

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List any medications you are currently taking (including over the counter):

***Please let us know if you would like us to ask your pharmacy to fax over your medication list.

_____

_____

_____

List any allergies:

1. _____
2. _____
3. _____

List any past surgeries or hospitalizations:

1. _____ YEAR: _____
2. _____ YEAR: _____
3. _____ YEAR: _____

Do you take blood thinners? ☐ YES ☐ NO Name of blood thinner:_____

Do you have a history of endocarditis? ☐ YES ☐ NO

Do you have history of any congenital (present from birth) heart conditions? ☐ YES ☐ NO

Have you been instructed by a physician to take an antibiotic before dental treatment? ☐ YES ☐ NO

Are you taking or have previously taken bisphosphonates for any reason? ☐ YES ☐ NO _____

Have you had any adverse reactions to general or local ("freezing") anesthetic? ☐ YES ☐ NO _____

Are you currently pregnant or breastfeeding? ☐ PREGNANT: _____weeks ☐ NO ☐ N/A

Social history:

*Please note that there will be no judgement, and answering honestly will help us provide you with better treatment. Local anesthetic ("freezing") given within 24 hrs of cocaine use can be dangerous.

Do you use any recreational drugs, including marijuana? ☐ YES ☐ NO Type and frequency:_____

Do you drink alcohol? ☐ YES ☐ NO If yes, how many drinks per week? _____

Do you smoke, vape, or chew tobacco? ☐ NO ☐ SMOKE ☐ VAPE ☐ CHEWING TOBACCO How often?_____

Oral Health:

When was your last dental cleaning? _____

How often do you brush your teeth? _____Floss? _____

What is your level of dental anxiety? ☐ LOW ☐ MEDIUM ☐ HIGH Is it to anything specifically?_____

_____ / /

AUTHORIZED SIGNATURE DATE