

Do you have any of the following conditions at present (Please circle Yes or No)

- Y / N New fever, cough, shortness of breath, difficulty breathing, sore throat or runny nose
- Y / N Loss of smell and or taste
- Y / N Recent exposure to infectious disease, e.g., measles, chicken pox or tuberculosis, COVID19
- Y / N Recent travel history
- Y / N New onset diarrhea
- Y / N New undiagnosed rash, lesion, or break in skin
- Y / N Shortness of breath at rest
- Y / N Inability to lie down because of difficulty breathing
- Y / N History of joint prostheses procedures in past two years
- Y / N History of antimicrobial therapy
- Y / N History of medications which could be immunosuppressive (e.g. chemotherapy)
- Y / N Family history of prion disease, or symptoms that may be indicative of CJD

Any other concerns: _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes / No

If Yes, please explain: _____

Are you now under the care of a physician? Yes / No

If Yes, please explain: _____

Name of Physician: _____ Phone #: _____

Do you have any other health issues or conditions not listed above that we should be aware of? Yes / No

If Yes, please list _____

DENTAL INFORMATION

Do you require premedication's prior to dental treatment? Yes / No _____

Have you ever had any complications following dental treatment? Yes / No

If Yes, please explain: _____

When was your last visit to the Dentist? _____

Do your gums bleed when you brush or floss? _____

Do your teeth experience sensitivity to hot or cold temperatures? _____

Do you grind or clench your teeth? (Either consciously or during sleep) _____

Do you have clicking/ popping/ pain associated with your TMJ joints? _____

Do you have pain associated with any of your teeth? _____

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Family Friend Work Advertising Internet

Name of person referring you to our practice: _____

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I consent to the dental procedures agreed to be necessary and advisable for myself or my child including the use of local anaesthetic, or other drugs as indicated.

I authorize the dentist to release any information including X-Rays, diagnostic and treatment records for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners.

I authorize my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balances on my account.

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the dentist. This authorization shall continue in effect until the undersigned revokes the same.

I hereby assign my benefits, payable from claims submitted electronically to the dentist, and authorize payment directly to him/her.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I consent to communicating with, and receiving information from Vista Landing Dental Clinic via phone, email and text messaging.

NAME (PLEASE PRINT)

Signature (Patient/Parent/Guardian)

DATE