Dr. Nick Seddon, DMD, FICOI
Cosmetic, Implant, and General Dentistry

PATIENT WELCOME FORM

Our mission is to cultivate long-term patient relationships through a high standard of individualized care by incorporating cutting-edge technology with an honest and compassionate dental team

The information on this form is important for our records and your health. This information is strictly confidential. Thank you for your cooperation. We look forward to caring for your dental needs.

PERSONAL INFORMATION

PATIENT'S LAST NAME / FIRST / MIDDLE INITIAL			DATE OF BIRTH	SEX
PREFERRED NAME		HOME PHONE #		CELL PHONE #
PATIENT'S ADDRESS	CITY	PROV.	POSTAL CODE	E-MAIL
MARITAL STATUS	PATIENT/GUARDIAN'S EMPLOYER			OCCUPATION
WORK ADDRESS	CITY	PROV.	POSTAL CODE	WORK PHONE #
SPOUSE'S LAST NAME / FIRST / MIDDLE INITIAL			SPOUSE'S EMPLOYER	OCCUPATION
SPOUSE'S WORK ADDRESS	CITY	PROV.	POSTAL CODE	WORK PHONE #
OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE				
WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?				
WHY DID YOU CHOOSE OUR PRACTICE?				

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP	
HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

WHAT IS THE PRIMARY NUMBER WHERE WE CAN CONTACT YOU? ☐ HOME ☐ WORK ☐ CELL

WHAT IS YOUR PREFERENCE FOR OUR OFFICE TO CONFIRM YOUR APPOINTMENTS?

☐ E-MAIL
☐ TEXT
☐ PHONE

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE YES ☐ NO ☐	INSURANCE COMPANY NAME		INSURANCE PHONE #
SUBSCRIBER NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF ☐ SPOUSE ☐ DEPENDENT ☐	SUBSCRIBER BIRTHDAY	CERT/ID#
DIVISION #	GROUP/POLICY NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)
SECONDARY COVERAGE YES ☐ NO ☐	INSURANCE COMPANY NAME		INSURANCE PHONE #
SUBSCRIBER NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF ☐ SPOUSE ☐ DEPENDENT ☐	SUBSCRIBER BIRTHDAY	CERT/ID#
DIVISION #	GROUP/POLICY NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)

Dundarave Dental Clinic
2461 Bellevue Avenue, West Vancouver, B.C. V7V 1E1
O: (604) 922-0144 • C: (778) 840-0762 • F: (604) 926-4015
W: www.DrNickSeddon.com • E: drseddon@dundaravedental.ca

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTH CARE WITH

	YES	NO
HEALTH CARE PROVIDERS	☐	☐
INSURANCE COMPANIES	☐	☐
OTHERS (SPOUSE, PARENTS, ETC.)	_____	
	_____	

ASSIGNMENT AND RELEASE

Dental insurance is designed to help aid in attaining optimum dental health; it is not designed to be a 'pay-all'. It is in your best interest to be sure that we have all of your current insurance information on file. We will do our best to answer any questions you have and are happy to process your claim forms at no charge.

We schedule your appointments to your convenience, and your punctuality is appreciated. If you need to reschedule your appointment, please provide us with two working days notice, in which case no cancellation fee will be applied.

I understand that I am responsible for payment of services rendered and that payment is due in full at the time of treatment unless prior arrangements have been agreed upon. I hereby authorize release of any information, either in print or electronic media, including the diagnosis and records of treatment or examination rendered, to my insurance company.

SIGNATURE PATIENT/GUARDIAN DATE

WITNESS SIGNATURE DATE

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DENTAL HISTORY

Referred by_____
Previous Dentist_____ How long have you been a patient?_____
Date of most recent dental exam _____ Date of most recent x-rays_____
Date of most recent treatment (other than periodontal therapy)_____
I routinely see my dentist every: ☐ 3 Months ☐ 4 Months ☐ 6 Months ☐ 12 Months ☐ Not Routinely
How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
How often do you brush your teeth? ☐ Twice a Day ☐ Once a Day ☐ Once Every Few Days ☐ Not Routinely
How often do you floss your teeth? ☐ Twice a Day ☐ Once a Day ☐ Once Every Few Days ☐ Not Routinely
WHAT IS YOUR IMMEDIATE CONCERN?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:		**YES**	**NO**
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most)? [ ]	☐	☐
2.	Have you had an unfavourable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or have your bite adjusted?	☐	☐
6.	Have you had any teeth removed?	☐	☐
BITE AND JAW JOINT			
7.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping, etc.)	☐	☐
8.	Do you / would you have any problems chewing gum, bagels, baguettes, protein bars or other hard foods?	☐	☐
9.	Have your teeth changed in the last 5 years, becoming shorter, thinner or worn?	☐	☐
10.	Are your teeth crowding or developing spaces?	☐	☐
11.	Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits?	☐	☐
12.	Do you clench your teeth in the daytime?	☐	☐
13.	Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
14.	Do you wear or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE			
15.	Have you had any cavities within the past three years?	☐	☐
16.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache?	☐	☐
20.	Do you get food caught between any teeth?	☐	☐
GUM AND BONE			
21.	Do your gums bleed when brushing or flossing?	☐	☐
22.	Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
23.	Have you ever noticed an unpleasant taste or odour in your mouth?	☐	☐
24.	Is there anyone with a history of periodontal disease in your family?	☐	☐
25.	Have you ever experienced gum recession?	☐	☐
26.	Have you ever had any teeth become loose on their own, or do you have difficulty eating an apple?	☐	☐
27.	Have you experienced a burning sensation in your mouth?	☐	☐

SMILE EVALUATION

1. Do you like the way your teeth look? ☐ Yes ☐ No
   Explain:_____
2. Are you happy with the colour of your teeth? ☐ Yes ☐ No
   Explain:_____
3. Would you like your teeth to be whiter? ☐ Yes ☐ No
   Explain:_____
4. Would you like your teeth to be straighter? ☐ Yes ☐ No
   Explain:_____
5. Do you have spaces between your teeth that you would like closed? ☐ Yes ☐ No
   If so, where?_____
6. Would you like your teeth to be longer? ☐ Yes ☐ No
   Explain:_____
7. Do you like the shape of your teeth? ☐ Yes ☐ No
   Explain:_____
8. Do you have missing teeth that you would like to replace? ☐ Yes ☐ No
   Explain:_____
9. Do you have old silver fillings that you would like to replace with tooth-coloured fillings? ☐ Yes ☐ No
   Explain:_____
10. If you could change anything about your smile, what would you change?

_____

_____

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MEDICAL HISTORY

Name of Physician and their specialty_____
Most recent physical examination_____Purpose_____Height_____Weight_____
How would you rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury	☐	☐
2. an allergic reaction to		
aspirin, ibuprofen, acetaminophen, codeine	☐	☐
penicillin, amoxicillin	☐	☐
erythromycin	☐	☐
tetracycline	☐	☐
sulpha	☐	☐
local anesthetic	☐	☐
fluoride	☐	☐
metals (nickel, gold, silver,_____)	☐	☐
latex	☐	☐
other_____	☐	☐
3. heart problems or cardiac stent in the last 6 months	☐	☐
4. history of infective endocarditis	☐	☐
5. artificial heart valve, repaired heart defect (PFO)	☐	☐
6. pacemaker or implantable defibrillator	☐	☐
7. artificial prosthesis (heart valve or joints)	☐	☐
8. rheumatic or scarlet fever	☐	☐
9. high or low blood pressure	☐	☐
10. a stroke (taking blood thinner)	☐	☐
11. anemia or other blood disorder	☐	☐
12. prolonged bleeding due to a slight cut (INR>3.5)	☐	☐
13. emphysema, sarcoidosis	☐	☐
14. tuberculosis	☐	☐
15. asthma	☐	☐
16. breathing or sleep problems (ie snoring, sinus)	☐	☐
17. kidney disease	☐	☐
18. liver disease	☐	☐
19. jaundice	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency	☐	☐
21. hormone deficiency	☐	☐
22. high cholesterol or taking statin drugs	☐	☐
23. diabetes (HbA1c=_____)	☐	☐
24. stomach or duodenal ulcer	☐	☐

	YES	NO
25. digestive disorders (ie gastric reflux)	☐	☐
26. osteoporosis/osteopenia (ie on bisphosphonates)	☐	☐
27. arthritis	☐	☐
28. glaucoma	☐	☐
29. contact lenses	☐	☐
30. head or neck injuries	☐	☐
31. epilepsy, convulsion (seizures)	☐	☐
32. neurologic problems	☐	☐
33. viral infections and cold sores	☐	☐
34. any lumps or swelling in the mouth	☐	☐
35. hives, skin rash, hay fever	☐	☐
36. venereal disease	☐	☐
37. hepatitis (type_____)	☐	☐
38. HIV/AIDS	☐	☐
39. tumour, abnormal growth	☐	☐
40. radiation therapy	☐	☐
41. chemotherapy	☐	☐
42. emotional problems	☐	☐
43. psychiatric treatment	☐	☐
44. antidepressant medication	☐	☐
45. alcohol/drug dependency	☐	☐
ARE YOU:		
46. presently being treated for any other illness	☐	☐
47. aware of a change in your general health	☐	☐
48. taking weight management meds (ie fen-phen)	☐	☐
49. taking dietary supplements	☐	☐
50. often exhausted or fatigued	☐	☐
51. subject to frequent headaches	☐	☐
52. a smoker or smoked previously	☐	☐
53. considered a touchy person	☐	☐
54. often unhappy or depressed	☐	☐
55. FEMALE – taking birth control pills	☐	☐
56. FEMALE – pregnant	☐	☐
57. MALE – prostate disorders	☐	☐

Describe any current medical treatment, impending surgery or other treatment

_____
_____
_____
_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Dosage	Date First Prescribed

Ask for an additional sheet if you are taking more than 5 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature:_____Date:_____

Doctor's Signature:_____Date:_____

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PHOTOGRAPHY CONSENT FORM / RELEASE

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I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I give permission for Dr. Nicholas J. Seddon Inc. to the use of these images without compensation to me (or child if underage) and waive any right to inspect or approve the finished product(s). All negatives, prints, digital reproductions shall be the property of Dr. Nicholas J. Seddon Inc.

I hereby warrant that I am of full age and have the right to contract in my own name/I am not of full age and this release is being executed by my parent/guardian whose signature is witnessed below. I/my guardian have read the above authorization, release, and agreement, prior to its execution and I/my guardian am fully familiar with the contents thereof. This release shall be binding upon me/my guardian, my heirs, legal representatives, and assigns.

_____
(Date)

_____
(Signature of Adult Subject)

_____
(Address)

_____
(City, Province, Postal Code)

_____
(Date)

_____
(Signature of Parent or Guardian)

_____
(Address)

_____
(City, Province, Postal Code)

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