



*Whistler Dental*

*For the smile you've always dreamed of...*

**Welcome to Our Office**

**Our mission....**Whistler Dental is a team of dental professionals who provide extraordinary dental care and exceptional customer service in a spa like environment. We provide these services for people willing to make an investment in their oral health. We are dedicated to our families, our community and our patients.

**GUEST REGISTRATION:** Today's Date (D/M/Y): \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth (D/M/Y): \_\_\_\_\_  
(Last) (First) (Middle Initial)

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ E-mail: \_\_\_\_\_

Telephone Home: \_\_\_\_\_ Pager/Cell: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
(Box #) (Street #) (City/town) (Prov/state) (Postal code/zip) (Country)

Residential Address: \_\_\_\_\_  
(Street #) (City/town) (Prov/state) (Postal code/zip) (Country)

Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_ Ext.: \_\_\_\_\_

If Child, Parent's or Legal Guardian's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

In case of Emergency, who should we contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_ Telephone: \_\_\_\_\_

**PRIMARY DENTAL INSURANCE:** *Patient's relationship to insured:*  Self  Spouse  Child  Other

Name of Insurance: \_\_\_\_\_ Group Policy #: \_\_\_\_\_ Division: \_\_\_\_\_

ID/Certificate #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth (d/m/y): \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE:** *Patient's relationship to Insured:*  Self  Spouse  Child  Other

Name of Insurance: \_\_\_\_\_ Group Policy #: \_\_\_\_\_ Division: \_\_\_\_\_

ID/Certificate #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Date of Birth (d/m/y): \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Telephone: \_\_\_\_\_

**HEALTH HISTORY:** *The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.*

Name of Physician: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_

Are you taking any medication? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what?

\_\_\_\_\_

Do you have any allergies or adverse reactions' to any medication? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what?

\_\_\_\_\_

**Please check any of the following that apply:**

- |  |  |
|--|--|
| <input type="checkbox"/> Heart murmur or other heart condition | <input type="checkbox"/> AIDS or HIV virus             |
| <input type="checkbox"/> Stomach intestinal problems           | <input type="checkbox"/> Abnormal bleeding or bruising |
| <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Ulcers                        |
| <input type="checkbox"/> Mental or nervous disorder            | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Low or high blood pressure            | <input type="checkbox"/> Ulcers                        |
| <input type="checkbox"/> Hyper (hypo) glycemia                 | <input type="checkbox"/> Hepatitis A, B or C           |
| <input type="checkbox"/> Epilepsy or seizures                  | <input type="checkbox"/> Heart attack or Stroke        |
| <input type="checkbox"/> Malignant hypothermia                 | <input type="checkbox"/> Pacemaker                     |
| <input type="checkbox"/> Drug addiction                        | <input type="checkbox"/> Liver disease                 |
| <input type="checkbox"/> Venereal disease                      | <input type="checkbox"/> Kidney disease                |
| <input type="checkbox"/> Any lung disease                      | <input type="checkbox"/> Injury to face or jaw         |
| <input type="checkbox"/> Thyroid disease                       | <input type="checkbox"/> Cancer: _____                 |
| <input type="checkbox"/> Arthritis or rheumatism               | <input type="checkbox"/> Scarlet or rheumatic fever    |
| <input type="checkbox"/> Anxiety attacks                       | <input type="checkbox"/> Pregnant                      |
| <input type="checkbox"/> Asthma                                | <input type="checkbox"/> Gag easily                    |
| <input type="checkbox"/> Smoker                                | <input type="checkbox"/> Other: _____                  |

**MEDICAL HISTORY UPDATED:**

Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_  
 Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_ Date \_\_\_\_\_ Initial \_\_\_\_\_

**GENERAL INFORMATION:**

Please Circle

- |  |     |    |
|--|-----|----|
| 1. Do you wish your teeth could be whiter? .....   | Yes | No |
| 2. Do you like the shape of your teeth? .....  | Yes | No |
| 3. Do you have spaces, chips, or uneven edges that bother you? .....                               | Yes | No |
| 4. Do you have chips or uneven edges? .....  | Yes | No |
| 5. Do you ever experience chronic pain in your jaw, shoulders or neck? .....                       | Yes | No |
| 6. Do you ever experience frequent headaches or earaches? .....                                    | Yes | No |
| 7. Do you have difficulty chewing food? .....  | Yes | No |
| 8. Does your jaw crack or pop when opened widely? .....  | Yes | No |
| 9. Do you have sensitive, broken, worn, loose or missing teeth? .....                              | Yes | No |
| 10. Do you have growths or sore spots in your mouth? .....   | Yes | No |
| 11. Do you feel your teeth shift or move? .....  | Yes | No |
| 12. If you wear a denture do you have any problems with it? .....                                  | Yes | No |
| 13. On a scale from 1 -10, 10 being very important how important is it to keep your natural teeth? |     |    |
| _____  |     |    |
| 14. If you could change anything about your smile, what would it be?                               |     |    |
| _____  |     |    |

**OFFICE INFORMATION FOR OUR GUESTS:**

- We will be happy to submit your insurance claim as a courtesy and you will be reimbursed directly by your insurance company. We ask that all treatment be paid for at time of service. For your convenience we accept Master Card, VISA, Debit or cash.
- Insurance is not a guarantee of payment; **you will not be reimbursed for the full amount paid at our office.**
- It is the patient’s responsibility to know the coverage and limitations of his/her Dental Insurance Policy.
- Upon your request, we can only give an estimate of what your insurance company may pay.
- Major work (crowns, bridges, root canals, implants) will require a 50% deposit before any treatment is started. This will reserve your appointment time.
- Our hygiene program is based on dental cleanings every 6 months. If you would like to be on a different schedule please notify our office.
- Appointments require 24 hours notice for cancellation or a fee may be charged.
- If there are any changes in your medical condition, please notify our dental office immediately.
- VIP Service. For your convenience, treatment can be charged directly to your credit card:  
# \_\_\_\_\_ Expiry \_\_\_\_\_  
Card Type: \_\_\_\_\_ Security Code (last 3 digits on back of card) \_\_\_\_\_
- Interest will be charged on all overdue accounts at a rate of 18%/year.

**I have read and understand the above information.**

**Guests Signature:** \_\_\_\_\_

**How were you referred to our office?** \_\_\_\_\_

**How can we make your dental experience exceptional?** \_\_\_\_\_

\_\_\_\_\_

**CONSENT FOR TREATMENT:**

I the undersigned, certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and will assume responsibility for fees associated with these procedures. I understand that I am responsible fro any and all charges regardless of insurance coverage.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR PHOTO'S:**

I herby give my consent to use my dental photos as Whistler Dental sees fit for the advancement of cosmetic dentistry education, viewing by other dental professional and in any promotional literate, with or without my name or with fictitious name. I release and forever discharge Whistler Dental from any claim, demands or liabilities on the account of such use.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_