Belleville and Quinte West Community Health Centre

## Belleville and Quinte West Community Health Centre Oral Health Program

Belleville & Quinte West Community Health Centre is a community-based primary health care organization that provides community-focused health promotion, illness prevention and comprehensive primary health care services including oral health services. The Centre has a vision for a healthier community where all people have access to quality care and services delivered with respect.

**PLEASE PRINT**

**Name**: _____ _____
(**Legal last name**) **(First name)**

**Date of Birth**: month/day/year: _____ **Age:** _____

**Gender**: Male ☐ Female ☐ Other: ☐ (specify)_____

**Ontario Health Card** # _____ Version Code: _____

**Preferred Language**: English ☐ French ☐ Other ☐ (specify): _____

**Home Address**:

_____
**(# and street name)** **(City)** **(postal code)**

**Telephone # Home:** _____ **Work:** _____ **Cell:** _____

**E-mail Address**: _____

### Emergency Contact Information

Name: _____Phone number:_____

Relationship: _____

Do you require any assistance? (Please include: mobility aids, hearing aids, visual difficulties, etc) _____

How did you hear about us? _____

### Dental Benefits

☐ **Ontario Works (OW)** ☐ **ODSP** ☐ **No dental benefits**

**If no dental benefits what is your combined household income: Total of all income in household. (you will be asked to verify your household income)**

☐ $0-14,999
☐ $15,000-19,999
☐ $20,000-$24,999
☐ $25,000-29,999
☐ $30,000-34,999
☐ $ More than $35,000

Number of people in **one** household who are supported by this income:_____

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## HEALTH CARE

Do you have a family doctor or nurse practitioner? **YES** ☐ **NO** ☐

Name: _____ Date of last medical checkup? _____

**Are you pregnant?** NO ☐ YES ☐ (expected due date): _____

Are you breast feeding _____

Have you had an **emergency department** visit in the last **2 months** for dental pain/infection?
NO ☐ YES ☐

**Known Allergies or reactions to medications (explain):**

_____

**Known allergies or reactions to other e.g. environmental/food (explain):**

_____

**Are you being treated for, or do you have any concerns with the following in the past year?**

- ☐ **Bleeding Problem/Disorder**
- ☐ **Bone/Joint Problems/Arthritis/Osteoporosis**
- ☐ **Asthma**
- ☐ **Prosthetic or artificial joint**
- ☐ **Stroke**
- ☐ **Diabetes**
- ☐ **COPD/Lung Problems**
- ☐ **Heart Attack**
- ☐ **Heart Disease/Heart Surgery/Heart Valve/Heart Murmur/Pacemaker**
- ☐ **Infective Endocarditis**
- ☐ **Congenital Heart Disease (from birth)**
- ☐ **Immune System (HIV, Leukemia, Chemotherapy, Radiotherapy)**
- ☐ **High Blood Pressure**
- ☐ **Hepatitis/Jaundice/Liver Disease**
- ☐ **Cancer (of: _____)**
- ☐ **Depression/Anxiety**
- ☐ **Mental Health - Please describe: _____**
- ☐ **Addiction/dependence issues (to:_____)**

**Do you have any conditions or diseases that have not been listed? If so please list:**

_____

**Do you take Aspirin or any Blood thinners?** _____

**Have you ever been told to take medication before a dental appointment?** ☐ ***Yes*** ☐ ***No***

**Do you smoke? How many cigarettes/day:** _____ **No** _____

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**Medications – please list each (or attach a print-out from Pharmacy)**

**Name of your preferred pharmacy:** _____Telephone#_____
Location: _____

| Prescribed Medication | Dosage | How Often? |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

**Over the Counter, Herbal, homeopathic or other health treatment products**

| Name | Dosage | How Often? |
|---|---|---|
| 1 | | |
| 2 | | |
| 3 | | |
| 4 | | |
| 5 | | |

**By signing this agreement I agree that all of the above information is true to the best of my knowledge.**

Applicant Signature (client) Date:

Signature: Relationship: Date:

*Please Note: If signed by person **other than** applicant, indicate relationship (Parent/guardian signature is required if applicant is under the age of 16 years)*

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## IMPORTANT INFORMATION ABOUT BQWCHC ORAL HEALTH PROGRAM

- **An appointment must be made for your visit**
- **Please arrive 10 minutes prior to your appointment time**
- **We are a busy dental clinic. If you arrive more than 10 minutes late for your appointment, your appointment will need to be rescheduled**
- ***You MUST have your eligibility card (OW/ODSP/Healthy Smiles) with you when you arrive for your appointment. If you do not have your card, we will have to reschedule your appointment***
- **It is very important that you attend your appointments. If you need to cancel, please provide us with 24 hrs notice of a cancellation (613) 962-0000 x263. When you do not attend your appointments and do not provide us with notice, we are unable to give your appointment time to someone else, like you, who is in need of our services**
- **If you have two consecutive "no-shows" without reasonable explanation, we may give you a 'wait period' before you can be seen by us again, or may ask you to get dental care elsewhere.**

**Signature:** _____ **Date:** _____