Patient Information

Patient Name: ____ Today's Date _________________________
Last **First** MI
Title: Mr. Mrs. Ms. Dr. Male Female Married Single Child Other _______________________
Birth Date: _________________________ Phone (Home): _____________________ (Cell) ______________________
Day/Month/Year
(Work): ________________________ Ext: _______ Email Address: ____
Home Address: ____
Street Unit/Apt #
____
City Province Postal Code
Parent/Guardian Name (for children under 18): ____
Last First MI
In case of emergency, who can we contact? ____
Last First
Emerg. contact phone number: ______________________________ Relationship: ______________________________

Health Information

Date of Last Dental Visit: ______________________________ Reason for today's visit: ______________________________

Have you ever had any of the following? Please circle those that apply:

Allergies (Pls circle): Penicillin, Codeine, Sulfa, Latex, Peanut, Ragweed/Seasonal or Other ____________
Anemia
Arthritis
Artificial Joints/Valves
Asthma
Blood Condition
Cancer
Diabetes
Drug/Alcohol Dependency
Epilepsy
Excessive Bleeding
Fainting
Head Injuries
Heart Disease/Murmur
Heart Attack/Chest Pain
Hepatitis
High/Low Blood Pressure
HIV/AIDS/STD
Hyper/Hypo Thyroid
Immune Deficiency
Kidney Disease
Liver Disease/Jaundice
Mental/Nervous Disorders
Osteoporosis
Pacemaker
Currently Pregnant Due Date: _________
Radiation/Chemo Treatment
Respiratory/Lung Problems/ Shortness of Breath
Rheumatic Fever
Sinus Problems
Steroid Therapy
Stomach Problems
Stroke
Transplant(s)
Tuberculosis
Ulcers/Cold Sores/ Canker Sores
Are you a smoker? Yes/No
Since Age _________
How much per day __
Cigarette's ________
Cigar _____________
Or Other __________
Other: _____________
____
____

Are your vaccinations current & up-to-date for: pertussis (whooping cough), diphtheria, tetanus, polio, varicella (chicken pox), measles, mumps & rubella? ___________________________________
Have you received any other vaccinations such as: human papilloma virus (HPV), influenza (flu shot), hepatitis A & B, herpes zoster (shingles), meningococcal meningitis & pneumococcal meningitis? (if yes, please specify which and when) _______
____
Are you currently taking any medications, vitamins, supplements or natural products? If yes, please list with dosage (mg):
____
Is there any medications that you were advised by your medical doctor **not** to take? Please list _____________________
____
Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain ____
Name of Physician: _______________________________________ Phone No.: ____________________________________
Date of last physical: ____
Do you have any health problems that need further clarification? Yes No
If yes, please explain: ____
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor/hygienist at the next appointment.

____ **Date:** ___________________________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Website ☐ Rate your MD ☐ Other_______________________________________

Name of person or office referring you to our practice: ____

Employment Information

Employer Name: ____________________________________ Occupation: _____________________________

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐Yes ☐No
Last First MI

Insured's Birth Date: __________________________ Female Male
Day/Month/Year

ID/Cert #: ___________________________ Group/Policy/Plan #:_________________________

Insured's Address: ____
Street City Province Postal Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other___________________

Insurance Company Name: ____

Secondary

Name of Insured: ____ Is insured a patient? ☐Yes ☐No
Last First MI

Insured's Birth Date: _________________________ Female Male
Day/Month/Year

ID/Cert #: ____________________________ Group/Policy/Plan #: ________________________

Insured's Address: ____
Street City Province Postal Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other___________________

Insurance Company Name: ____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_________________________________ Date: ______________________ Relationship to Patient: ___________________________
Signature of patient, parent or guarantor