**Patient Information**

Patient Name:

 Last First MI (Preferred Name)

 Gender:  Birth Date:

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ day/month/year

Phone (Home):  (Work):  Cell: \_\_\_

Address:

 Street Apartment #

 City Province Postal Code

**Health Information**

Date of Last Dental Visit: Reason for this visit:

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

|  |
| --- |
|  AIDS |
|  Allergies \_\_\_\_\_\_\_\_\_\_ |
|  \_\_\_\_\_\_\_\_\_\_ |
|  Anemia  |
|  Arthritis |
|  Artificial Joints |
|  Asthma |
|  Blood Disease |
|  Cancer |
|  Diabetes |
|  Dizziness |
|  Epilepsy |
|  Excessive Bleeding |
|  Fainting |
|  Glaucoma |
|  Growths |
|  Hay Fever |
|  Head Injuries |
|  Heart Disease |
|  Heart Murmur |
|  Hepatitis |
|  High Blood Pressure |
|  Jaundice |
|  Kidney Disease |
|  Liver Disease |
|  Mental Disorders |
|  Nervous Disorders |
|  Pacemaker |
|  Pregnancy |
|  Due date:\_\_\_\_\_\_\_\_\_ |
|  Radiation Treatment |
|  Respiratory Problems |
|  Rheumatic Fever |
|  Rheumatism |
|  Sinus Problems |
|  Stomach Problems |
|  Stroke |
|  Tuberculosis |
|  Tumors |
|  Ulcers |
|  Venereal Disease |
|  CPAP Machine |
|  Sleep Apnea |
|  Low Blood Pressure |
|  Osteoporosis  |
|  Acid Reflux  |
|  OTHER: |

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

 If yes, please explain:

• 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:

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 doctors at the next appointment without fail.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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  Yellow Pages  Newspaper  School  Work  Other

Name of person or office referring you to our practice:

**Emergency Contact / Responsible Party Information**

The following is for:  the patient's spouse  the person responsible for payment  Emergency Contact

Name:

Phone #: (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Work): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: \_\_\_\_\_\_ (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

**Primary**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is insured a patient?  Yes  No

 Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

 Street City Province Postal Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address:

**Secondary**

Name of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is insured a patient?  Yes  No

 Last First MI

Insured's Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #:

Insured's Address:

 Street City Province Postal Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name and Address:

**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.

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.

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 opt IN to the electronic confirmation system

I opt OUT to the electronic confirmation system

If, for any reason, you need to cancel, we ask that you do so with greater than 48 hours of notice. If you do not appear for the appointment as scheduled or give us less than 48 hours’ notice a cancellation fee will be applied to your account of $100.00.

For evening appointments you will need to notify us by 4:30pm two business days prior to the appointment. This allows us some time to attempt to fill that spot.

If your appointment is for a Monday (or Tuesday after a long weekend) you would need to notify us by 4:30pm two business days prior. This allows us some time to attempt to fill that spot.

If you are charged the cancellation fee it will be billed to your account, and must be paid prior to scheduling any other appointments.

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:

Signature of patient, parent or guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient:

Signature of guarantor of payment/responsible party