# 2.04 Patient Information

Name: ❑Male ❑Female DOB: Year: Month: Day: Age:

Name of Parent/Guardian: Work: ( ) -

Home: ( ) - Cell: ( ) - Please Use: qWork qHome qCell

Email:

Address:

City: Province: Postal Code:

Mailing Address:

City: Province: Postal Code:

Emergency Contact: Relationship: Phone: ( ) -

Previous Dentist: Date of last Dental Visit: Year: Month: Day:

Whom may we thank for referring you to our office?

**Check ALL that apply.**

*Do you have or have had:*

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, defect, mitral valve prolapse
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

*Do you smoke or use chewing tobacco?*

❑ Y ❑ N

*Are you allergic to, or have reacted adversely to:*

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:____ _____ _____ _____ _____

*Are you taking any of the following?*

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

*Women:*

- ❑ May be pregnant Expected delivery date: _____ _____ ___
- ❑ Taking hormones or contraceptives
- ❑ Nursing

Your Physician: Date of Last Visit: Year: Month: Day:

Do you have any disease, condition, or problem not listed above?

Is there anything else you would like us to know about?

Signature of patient/guardian:

## YOUR DENTAL PLAN INFORMATION

Primary Plan (For children: the parent who's birth month comes first in the year is the Primary Plan):

Group # Insurance Company:

Id or Certificate # Employer/Company Name:

Subscriber/Policy Holder's Name: DOB: Year: Month: Day: Age:

Will this plan allow payment to the Dentist? Yes or No

**Secondary Plan:**

Group # Insurance Company:

Id or Certificate # Employer/Company Name:

Subscriber/Policy Holder's Name: DOB: Year: Month: Day:

Will this plan allow payment to the Dentist? Yes or No

## FINANCIAL POLICY

❑ **OPTION 1—Regular Claim:**

- All accounts are paid by you, at the time of service, and the Insurance Claim (if any) is sent electronically by our office at the time of your appointment. The Insurance payment is mailed directly to you and may be received in as little as three days.
- I, the undersigned, hereby agree to the Financial Policy of Dental Centre as outlined above.

❑ **OPTION 2 — Direct Billing:**

- For direct billing insurance providers, a credit card must be on file for outstanding amounts owing after insurance claims. Each insurance provider has fee guides to calculate your coverage. Insurance providers pay a percentage of their fee guide, not a percentage of our office fee guide. Because of this, it is impossible to estimate exactly how much your Insurance provider will reimburse you. We strive to accurately estimate for reimbursement; however, there may be a balance owing. For balances owing under $100, your card will be automatically charged. For balances over $100, we will attempt to contact you, and mail you a receipt with a copy of the Explanation of Benefits from your Insurance provider.

I agree to the above financial policy and authorize My Smile to apply any outstanding balance on my account, not covered by my Insurance provider, to the credit card listed below:

Cardholder Name: Authorization Signature:

❑Visa ❑MasterCard ❑American Express

Card #: CC Code On Back: Expires: Year: Month:

## Treatment Consent

I, the undersigned authorize {Dental Centre} to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand that any and all dental services are my sole responsibility and that I should make myself aware of any fees associated with my dental care prior to treatment.

Signature: Print Name: Date: Yr Mon: Day:

## Office Policy

Your appointment time will be reserved especially for you. If you are unable to keep your scheduled visit, we ask for 2 business days' notice. Advance notice allows our office to see other patients who may have been waiting for us for needed treatment. We thank you in advance for your consideration.