

NEW PATIENT FORM

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

PHONE: _____ OTHER PH #: _____

EMAIL: _____

REFERRED BY: _____ PHYSICIAN: _____

OCCUPATION/EMPLOYER: _____

INSURANCE CARRIER: _____

GROUP/ PLAN #: _____ CERT/ ID #: _____

MEDICAL HISTORY

Please check

YES

NO

1. Have you ever had a serious illness or are you under the care of a physician now? YES NO
2. Have you ever had a medical examination in the last year? YES NO
3. Do you use any medications now? YES NO
4. Have you had any of the following diseases? (Please Circle)
Hepatitis, jaundice, diabetes, high blood pressure, tuberculosis, any lung disease,
venereal disease, kidney disease, heart murmur or heart disease, stroke, epilepsy,
cancer, thyroid disease. Mental or nervous disease, arthritis or rheumatic fever,
stomach problems, allergies, AIDS YES NO
5. Do you ever have asthma, hay fever, hives or skin rash? YES NO
6. Has any member in your family had diabetes? YES NO
7. Have you ever experienced any unusual reaction to any of the following drugs?
(Please Circle) Aspirin, penicillin, iodine, sulfonamide (sulfa),
barbiturates (sleeping pills), local anesthesia or other medicine YES NO
8. Do you bruise easily or bleed abnormally? YES NO
9. Do you have any blood disorders such as anemia (thin blood)? YES NO
10. Have you ever had any injury, surgery or X-ray therapy to your face or jaws? YES NO
11. Do you have the tendency to faint? YES NO
12. Do you have frequent severe headaches? YES NO
13. Do you have a prosthetic implant? YES NO
14. WOMEN ONLY- Are you pregnant (Which month _____) YES NO
15. Do you have any disease, condition or problem not listed above that you think
the doctor should know about? _____

DENTAL HISTORY

1. Have you had regular dental examination (annually) in the past YES NO
2. Do you have any oral habits such as clenching, grinding your teeth
or nail biting? YES NO
3. Have you ever had tooth brushing instructions? YES NO
4. Have you ever had instruction in using dental floss? YES NO
5. What concerns you most about your dental health? _____

Patient's Signature: _____ Date: _____

OFFICE POLICIES

- All treatment must be paid for at the time of service. For your convenience we accept Mastercard, Visa, Interac, cheque or cash. We do accept assignment of benefits from most dental insurance carriers, however, any fees not covered by your plan remain the responsibility of the patient and must be remitted in full.
- It is each patient's responsibility to know the limitations of their own dental insurance policy - please be aware of what is covered, what will be paid for and any changes that may occur with your plan from time to time. Your insurance plan will not disclose details of your plan to us and will not inform us of changes that may be made to it.
 - We do not recommend treatment based on the terms and consideration of your insurance plan, rather on the individual needs of patient
- We are only able to give you an estimate of what your insurance company may pay toward any particular treatment. Any remaining differences is the sole responsibility of the patient.
- Insurance companies base their reimbursement on the fee guide published by the BC Dental Association. However, not all plans remit based on the current fee guide, which is what our office operates under. Therefore, you may be required to pay more than the percentage that was estimated for at the time of the treatment.
- All treatment will be discussed with you prior to commencing a procedure and a fee estimate can be provided upon request. A pre-determination can be sent in order to obtain a clear response from your insurance carrier as to what amount they may contribute toward a particular course of treatment. Unfortunately, this course of action can take up to 6 weeks or more before a response is provided.
- We work very hard to run on time and ask you to arrive promptly for your scheduled appointment. Delays upon arrival can result in treatment having to be rescheduled.
- We require **2 business days'** notice (48 hours) to accept cancellation of an appointment or a fee may be charged.
- Patients that fail to arrive promptly for scheduled appointments or fail to provide adequate notice of scheduled changes may be dismissed from the practice.
- Overdue accounts will be charged 5% interest per month. If a bill is unpaid for more than 60 days a collection agency will be used to manage delinquent accounts. You will be responsible for all the costs associated with collection.
- VIP Service- For your convenience, treatment can be charged directly to your credit card. Your card number and expiry date will be kept on account with us in a confidential manner. Please provide your account information to our receptionists directly.

Patient's Signature: _____ **Date:** _____