WELCOME to west 17th avenue dental care

WWW.WEST17AVEDENTAL.CA

We are pleased to welcome you to our clinic!
Please take a few minutes to fill out this form as completely as you can.
If you have questions, we'll be glad to help you. Thank you.

PATIENT INFORMATION

NAME_____ _____ **GENDER** □ M □ F
Last *First* *Initial* *"preferred name"*

BIRTHDATE _____ □ Single □ Married □ Child □ Other
dd / mm / yyyy

ADDRESS_____ **CITY**_____ **PROVINCE**_____
POSTAL CODE _____

PHONE (Home)_____(Work)_____Ext:_____
(Cell)_____(Fax)_____

EMAIL_____ **EMPLOYER**_____

BEST TIME / METHOD TO CONTACT YOU_____

HOW DID YOU HEAR ABOUT OUR OFFICE?

YELLOW PAGES ___ NEIGHBOURHOOD MAIL ___ EXTERIOR SIGN ___

ANOTHER PATIENT *name _____ OTHER _____

Have you visited our website recently? Y ___ N ___

DENTAL INSURANCE (if applicable)

PLEASE FORWARD YOUR INSURANCE WALLET CARD(S) / INFORMATION TO THE FRONT DESK BEFORE YOUR APPOINTMENT BEGINS.

This ensures we submit the correct information to your insurance provider.
Most submissions can be completed "on-line", thus speeding up your reimbursement.
This will be done on your behalf (and with your permission) at the completion of your appointment.

IF THE PRIMARY POLICY HOLDER IS NOT YOURSELF please indicate the information below:

NAME OF POLICY HOLDER & THEIR EMPLOYER _____

YOUR RELATIONSHIP TO POLICY HOLDER_____ **BIRTHDATE** _____
dd / mm / yy

YOUR DENTAL HISTORY

What would you like us to do today? _____

- Are you in dental discomfort today? □ Y □ N If yes, when did it start? _____
- Approx. date of last dental care _____

Have you ever had an unpleasant dental experience? (or any complications following treatment)
please explain _____

PLEASE INFORM A TEAM MEMBER IF THERE IS ANYTHING WE CAN DO TO MAKE YOUR VISIT MORE COMFORTABLE

Check (√) if you have had problems with any of the following:

□ BAD BREATH
□ BLEEDING GUMS
□ LOOSE TEETH OR BROKEN FILLINGS
□ FOOD COLLECTION BETWEEN TEETH
□ GRINDING OR CLENCHING TEETH
□ CLICKING OR POPPING JAW
□ ORTHODONTIC TREATMENT

YOUR MEDICAL HISTORY

GENERAL PHYSICIAN'S NAME_____ **PH. NUMBER / not nec.**_____

APPROX.DATE OF LAST EXAM if applic._____

Are you now under the care of a physician? □ Y □ N If YES, please explain_____

Have you been admitted to a hospital, or needed emergency care during the past 2 years? □ Y □ N

If YES, please explain _____

Check (√) if you are ALLERGIC to, or have had any reaction to the following

Local Anesthetic	□	Any metals (nickel, mercury, etc.)	□
Penicillin (or any other antibiotics)	□	Latex rubber	□
Sulfa Drugs	□	Sedatives	□
Codeine	□	Aspirin	□

Other (please list) _____

Do you use tobacco? □ frequency? _____
Do you use illegal / controlled substances? □ frequency? _____

Please LIST *ALL* MEDICATIONS you are currently taking (including NON-PRESCRIPTION)

_____
_____
_____
_____
_____

Check (√) if you have / had any of the following

□ High Blood Pressure ***MEDICATED Y / N***
□ Heart Attack
□ Rheumatic Fever
□ Fainting
□ Diabetes ***INSULIN Y / N***
□ Respiratory problems
□ Mitral Valve Prolapse
□ Artificial: joints/ implants/ valves/ pacemaker
Describe_____
□ Hepatitis ***(TYPE____)***

□ Low Blood Pressure
□ Asthma ***INHALER Y / N***
□ Mouth sores (herpes)
□ Excessive Bleeding
□ Nervous problems
□ Epilepsy / Convulsions
□ AIDS / HIV infection
□ Rapid weight gain / loss
□ Glaucoma
□ Psychiatric care
□ Hay Fever
□ Alcohol / Substance Abuse

□ Headaches
□ Sinus problems
□ Heart murmur
□ Heart disease
□ Sexually Transmitted Disease
□ Stomach problems / Ulsers
□ Stroke
□ Kidney Disease
□ Chest Pains
□ Thyroid disease/malfunction
□ Cancer (growths/tumors) ***CHEMO. Y / N***
□ Jaundice

WOMEN ONLY : (please circle if applic.)

*Are you pregnant? **Y N** *Are you nursing? **Y N** *Are you taking oral contraceptives **Y N**

CONSENT FOR TREATMENT
& USE OF YOUR PERSONAL INFORMATION

- I have reviewed all information on this questionnaire and it is accurate to the best of my knowledge.
  I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment.

West 17 Avenue Dental Care is in compliance with all the guidelines of the revised 'Privacy Act'. We cannot discus your personal information at the front desk, however we do need to keep this data updated.
If there is any change in your personal information, please inform a Team member **before** commencing your scheduled treatment for that day (including address or insurance status changes.
This information will only be used in a responsible and professional manner.

- ***I agree to be responsible for payment of all services rendered on my behalf or my dependants.***
  I understand that payment is due at the time of service.
  Any other arrangements must be made ahead of time.

- I understand if I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. A finance charge of 24% per annum of the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are made. If an account requires an outside party for collection, a collection fee will also be added to the account. (30% +tax of the total balance owing)

If you have dental insurance, ***we recommend that you contact your insurance company directly with any questions.*** **In accordance with the 'Privacy Act' this information is considered "confidential medical information" and as such, it will NOT be released to us.**

This office will help prepare the patients' insurance forms, however this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
Our fees reflect the current cost of our supplies, equipment, education, and services, and
it is likely that there will be a difference between our current fees and the fees used by your dental insurance plan.

- I understand as a condition of treatment by this office, **cancellations or changes require 48 hours notice** given directly to administration personnel, not the answering service.

If appropriate notice is not received, a fee may be incurred,
and I agree that this, as well as any previous outstanding balances, will be my responsibility.

- I understand that the fee estimate listed for my dental care will only be extended for a period of 30 days from the date of the patient examination.

I have read the above conditions of treatment and payment and agree to their content.
I consent to the collection, use and disclosure of my personal information as set out above

X _____ _____

Signature of patient, parent or guardian ***Date***