PATIENT INFORMATION

(or Responsible Party if under the age of 18)

Last Name:	First Name:	Preferred Name: (if different)	
			❑ Male ❑ Female

Street address: (Include apt or unit number)	City:	Province / Postal code:

Home number: ❑ Preferred	Cell number: ❑ Preferred	Prefer Appointment Reminders by:
		Call Text Email

E-Mail Address: ❑ Preferred	Date of Birth: (MONTH / DAY / YEAR)
	/ /

Do you have dental insurance? ❑ Yes ❑ No	Government issued ID # & type:

How did you hear about our office:

Other family members seen here:

It is our goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. To help us best serve your dental needs, please note our office policies.

Reservation Policy * Appointment reminders are sent by email or text message *****

If you need to reschedule your appointment we require at least 2 business days' notice or a fee of $50 may be applied. The reason for this is, we have patients on our priority list that require an appointment on short notice – they are suffering or they are in pain. It is important to our doctors that we see those patients as quickly as possible. Patients who are consistently missing reserved appointments will not be able to pre-schedule their next appointment. Thank you for your understanding.

_____ _____

Patient/Parent Signature Staff Signature

Payment Policy

Payment is due in full upon completion of all treatment rendered in our office if you have dental insurance benefits please be aware that Dental insurance is an agreement between your employer, yourself and your insurance company. We work with most insurance companies and always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. Due to the Canadian Privacy Act that has evolved through the years to protect your privacy, most insurance companies will release very limited information to us. Insurance companies also will not give us information on services billed by any other dental office. We will be happy to handle the first submission to your insurance company (primary and secondary if applicable), however if we do not receive payment within 60 days you will become responsible for any outstanding balance and any further negotiations with your insurer. We do our best to provide you with an accurate estimate; however you are responsible for any balance not paid by your insurance.

By signing this form you are consenting that you have read the above office policies and understand your responsibilities as a patient and/or responsible party. You are also consenting to the release, of your dental benefits plan administrator and CDA net, information contained in claims submitted to your insurance on your behalf. You have also authorized the communication of information related to your coverage of service described to the named dentist. You also hereby assign your benefits, payable from claims submitted on your behalf, to Elgin Corners Dental and authorize payment directly to the provider.

Thank you and we look forward to taking care of your oral health needs and welcome you to our office.

_____ _____ _____

Print Account Holder Name Account Holder Signature Date (MONTH / DAY / YEAR)

Staff Initials _____

ELGIN CORNERS DENTAL
Family & Cosmetic Dentistry

Medical History

Are you currently under the care of a physician? YES NO

Physician Name_____ Phone Number_____

Reason for last visit: _____

_____

Have you ever had a serious illness, operation, or been hospitalized? If so, please explain_____

_____

Have you ever had or been treated for: (please circle)

Blood pressure (high or low)	High cholesterol	Heart Disease	Stroke	Rheumatic Fever
Heart Valve Replacement	Heart Murmur	Hepatitis A B C	Diabetes	Artificial Joint
Immunocompromised Disease	Tuberculosis	Bleeding Disorder	Asthma	Dry Mouth
Depression / Anxiety	Psychiatric Care	Osteoporosis	Epilepsy	Cancer
Kidney Problems	Bisphosphonate use	HIV Positive	AIDS	

Other:_____

Have you ever had an allergic reaction to: (circle) Penicillin Erythromycin Latex Tetracycline Sulfa Codeine

Other/Food_____

Please list all prescription medication_____

_____

Please list all other medications (over the counter, supplements, herbal remedies, etc)_____

_____

Have you ever needed to premedicate with antibiotics prior to dental appointments? YES NO

Do you now or have you ever used tobacco products? If so how long ago?_____ YES NO

Have you used any recreational drugs in the last 6 months? YES NO

If YES, please specify _____

For women: Are you trying to conceive, pregnant or nursing? YES NO

Do you take birth control pills? YES NO

Dental History

Date of last dental visit _____ Reason for last visit_____

Do you have any concerns about previous dental care?_____

_____

Are you teeth sensitive to (please circle) Sweets Cold Hot Pressure

Have you had orthodontic treatment in the past? YES NO

Do you wear a retainer? YES NO

Are you happy with your smile? YES NO

What would you change about the present condition of your mouth?_____

_____

All information collected on this form is strictly confidential. By signing this form you are consenting that you understand the need for these questions to be answered truthfully, accurately and to the best of your knowledge. You also understand it is very important to report any changes or updates to your medical status as soon as possible. You also give permission to obtain any additional information from the physician regarding your medical history needed to provide you with the best treatment possible. Also you authorize and consent to perform tests/x-rays and treatment as required.

_____ _____ _____

Print Patient Name Signature Date (Month / Day / Year)

Staff Initials _____