**PLEASE FILL IN ALL FIELDS**

**PATIENT INFORMATION** A Parent or Guardian will be responsible for decisions relating my treatment YES ☐ NO ☐

Name: _____
First Initial Last

Date of Birth: ____/____/____ (D M Y) Email: _____

Cell Tel: _____ Home Tel: _____ Work Tel: _____

Address: _____
Street City Postal Code

Preferred method of contact: Home # ☐ Work # ☐ Cell # ☐ Text ☐ Email ☐

☐ I agree to be added to your Facebook page ☐ I agree to subscribe to your newsletter

Preferred time and day for appointment (check all that apply) ☐ Morning ☐ Afternoon ☐ Evening

☐ Monday ☐ Wednesday ☐ Friday ☐ Sunday
☐ Tuesday ☐ Thursday ☐ Saturday

Family Dr: _____ Tel: _____
Emergency Contact: _____ Tel: _____

**How did you hear about us?**

Referred by (Insert name) ☐ Patient _____ ☐ Family Doctor _____
☐ Bus Shelters ☐ Mobile Sign ☐ Advertising around Shoppers World Mall
☐ Convenient location ☐ Google/Search Engine ☐ Online Review _____
☐ www.tridont.com ☐ Web Marketing ☐ Other (specify) _____

**INSURANCE INFORMATION**

Do you have extended health or dental insurance? YES ☐ NO ☐
If yes, please provide your card to receptionist, they will make a copy for your file.

**DENTAL HISTORY**

1. What is the reason for today's visit? _____
2. When was your last dental visit? _____
3. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____
4. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never

| | YES | NO |
|---|---|---|
| 5. Do your gums feel swollen or tender? | ☐ | ☐ |
| 6. Do you have bad breath or a bad taste in your mouth? | ☐ | ☐ |
| 7. Do you have food catch between your teeth? | ☐ | ☐ |
| 8. Have you ever had local anaesthetic (freezing) | ☐ | ☐ |
| If yes, were there any complications? (Please specify) | ☐ | ☐ |
| 9. Have you had any problems with previous dental treatments? Specify | ☐ | ☐ |

10. Have you had any of the following: ☐ Bridgework ☐ Crowns or Caps
☐ Full or Partial Denture ☐ Orthodontic (Braces) ☐ Periodontal (Gums) ☐ Root Canal

| | | |
|---|---|---|
| 11. Are you satisfied with your teeth? | ☐ | ☐ |
| 12. Do you have Sleep Apnea? | ☐ | ☐ |

If yes, are you using any of the following: ☐ CPAP machine ☐ Oral Appliance

(Continued on reverse side)

**MEDICAL HISTORY** (this information will remain confidential)

| | YES | NO |
|---|---|---|
| 1. Are you presently under the care of a physician? If so explain_____ | ☐ | ☐ |
| 2. Have you ever had a serious illness or been hospitalized? If so explain_____ | ☐ | ☐ |
| 3. Are you taking any Drugs or medication at this time? | ☐ | ☐ |
| 4. Do you suffer from any allergies (hay fever, latex, etc.)? If so which ones?_____ | ☐ | ☐ |
| 5. Do you bruise easily or have prolonged bleeding? _____ | ☐ | ☐ |
| 6. Have you ever fainted, had shortness of breath or chest pains_____ | ☐ | ☐ |
| 7. Have you ever been warned against using any medication? If so which?_____ | ☐ | ☐ |
| 8. Have you ever taken prolonged medical or non-medical drugs? Specify _____ | ☐ | ☐ |

9. Have you ever had an adverse effect to any of the following?

☐ Aspirin ☐ Barbiturates (sleeping pills)
☐ Codeine ☐ Darvon ☐ Local Anaesthetic
☐ Antibiotics: ☐ Penicillin ☐ Sulfonamide

| 10. Women: | YES | NO |
|---|---|---|
| Are you pregnant?_____ | ☐ | ☐ |
| Have you reached menopause? _____ | ☐ | ☐ |
| Are you taking birth control? _____ | ☐ | ☐ |

11. Do you or have you ever had any of the following: Please check off appropriate circles

| | | | | |
|---|---|---|---|---|
| ○ A.I.D.S. | ○ Cancer | ○ Heart disease/attack | ○ Jaundice | ○ Rheumatic/Scarlet fever |
| ○ Anemia | ○ Circulation Problems | ○ Heart murmur | ○ Kidney disease | ○ Sickle cell disease |
| ○ Angina pectoris | ○ Congenital heart lesion | ○ Heart Pacemaker/surgery | ○ Liver disease | ○ Sinus Trouble |
| ○ Anorexia nervosa | ○ Cortisone/steroid | ○ Heart rhythm disorder | ○ Leukemia | ○ Stomach/intestinal prob. |
| ○ Arthritis/rheumatism | ○ Diabetes | ○ Hepatitis A/B/C | ○ Lung disease | ○ Stroke |
| ○ Artificial heart valve | ○ Drug/Alcohol dependence | ○ Herpes | ○ Malignant hyperthermia | ○ Thyroid disease |
| ○ Artificial joints (hip, knee) | ○ Emphysema | ○ High/Low blood pressure | ○ Mental/nervous disorder | ○ Tuberculosis |
| ○ Asthma | ○ Epilepsy or seizures | ○ H.I.V. positive | ○ Mitral valve prolapsed | ○ Ulcers |
| ○ Blood Disorders | ○ Glandular disorders | ○ Hodgkins disease | ○ Organ transplant/implant | ○ Venereal disease |
| ○ Bronchitis | ○ Glaucoma | ○ Hyper (Hypo) Glycemia | ○ Psychiatric treatment | ○ Other_____ |
| ○ Bulimia | ○ Head/neck injuries | ○ Hypertension | ○ Radiation/Chemotherapy | ○ None |

12. Children only: Have you recently had any of the following (approximate date)

☐ Chicken Pox ☐ Measles ☐ Mumps
☐ Strep Throat ☐ Tonsillitis

**GENERAL RELEASE**: I, the undersigned, understand that the information contained in the dental and medical history portion of this chart is important to my treatment. I certify that all the information is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health provider as required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____
Signature ☐ Patient ☐ Parent ☐ Guardian Print Name Date

_____ _____ _____
DDS Signature DDS Print Name Date

Dentistry on Dundas

# DENTAL OFFICE POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

**General:**
Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

**MISSED APPOINTMENTS:**
Unless we receive notice of cancellation **48 hours** in advance, you will be charged **$50.00**. Please help us service you better by keeping scheduled appointments.

**INSURANCE:**
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It **is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you.** If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

*I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.*

- *I hereby assign my benefits, payable from claims submitted electronically, to **Dentistry on Dundas**, and authorize payment directly to the office. This authorization shall continue in effect until the undersigned revokes the same.*

(Continued on reverse side)

Dentistry on Dundas

**PAYMENT:**
FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS** and **DEDUCTIBLES** are due at the time of service, unless other arrangements are made.

**If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.**

**I have read, understand and agree to the terms and conditions of this Financial Agreement.**

**Patient Name:** _____

**Signature:** _____ **Date:** _____