City Smiles DENTAL

PATIENT REGISTRATION
Welcome to our office!

Patient Registration: Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐

Are you the: ☐ PATIENT ☐ PARENT (Guardian)

Last Name: _____ First Name: _____

Street Address: _____ APT/Unit: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: D: _____ M: _____ Y: _____ Sex: M ☐ F ☐ Email Address: _____

Phone (H): _____ Phone (M): _____ Phone (W): _____

Driver's License: _____ OHIP No: _____

Emergency Contact Name: _____ Phone #: _____

FINANCIAL INFORMATION

Method of Payment: Mastercard ☐ Visa ☐ American Express ☐

* Health Spending accounts are to be remitted by patient. Our office is unable to remit on your behalf.

PRIMARY INSURANCE

Employer Name: _____ Insurance Company Name : _____

Policy Holder Name and DOB: _____

Policy #: _____ Certificate: _____ ID #: _____

SECONDARY INSURANCE

If you have a secondary insurance plan, usually through your spouse, your claim must always be submitted to your plan first. Once that claim has been processed we will be happy to submit to your secondary insurance.

Employer Name: _____ Insurance Company Name : _____

Policy Holder Name and DOB: _____

Policy #: _____ Certificate: _____ ID #: _____

➢ **PLEASE TURN OVER**

MEDICAL HISTORY

YES NO

1. Are you presently under the care of a physician? If so, explain. _____ ☐ ☐

2. Have you ever been hospitalized? Explain _____ ☐ ☐

3. Are you taking any drugs or medication at this time?_____ ☐ ☐

A) Drug _____ Reason: _____

B) Drug _____ Reason: _____

C) Drug _____ Reason: _____

4. Have you ever had any adverse effect to any of the following: Antibiotic - Penicillin ☐ , Sulfonamide ☐ ,

Other ☐ **Aspirin** ☐ **Barbiturates (sleeping pills)** ☐ **Codeine** ☐ **Darvon** ☐ **Local Anaesthetic** ☐ **NONE** ☐

5. Have you ever been warned against using any other medications? Which?_____

6. Have you ever taken prolonged medical or non-medical drugs? Which?_____

7. Do you suffer from any allergies (hay fever, latex etc.)? Which?_____

8. Do you bruise easily or have prolonged bleeding?_____

9. Do you smoke? How much per day?_____

10. Have you ever fainted, had shortness of breath or chest pains?_____

11. Are you pregnant? ☐ Yes ☐ No Using birth control? ☐ Yes ☐ No Reached menopause? ☐ Yes ☐ No

12. Do you have or have ever had any of the following? Please √ appropriate boxes.

☐ A.I.D.S	☐ Cortisone/steroid	☐ High/Low Blood pressure	☐ Psychiatric disorders
☐ Anemia	☐ Diabetes	☐ H.I.V. Positive	☐ Radiations/Chemotherapy
☐ Angina pectoris	☐ Drug/Alcohol dependence	☐ Hodgkin disease	☐ Rheumatic/Scarlet fever
☐ Anorexia nervosa	☐ Emphysema	☐ Hyper (Hypo) Glycemia	☐ Sickly Cell disease
☐ Artificial Heart valve	☐ Epilepsy	☐ Hypertension	☐ Sinus Trouble
☐ Arthritis/rheumatism	☐ Glandular disorders	☐ Jaundice	☐ Intestinal problems
☐ Artificial joints	☐ Glaucoma	☐ Kidney disease	☐ Stroke
☐ Asthma	☐ Head/Neck Injuries	☐ Liver disease	☐ Thyroid disease
☐ Blood disorders	☐ Heart disease/attack	☐ Leukemia	☐ Tuberculosis
☐ Bronchitis	☐ Heart murmur	☐ Lung disease	☐ Ulcers
☐ Bulimia	☐ Heart pacemaker/surgery	☐ Malignant hypothermia	☐ Venereal disease
☐ Cancer	☐ Heart rhythm disorder	☐ Mental/nervous disorder	☐ Other_____
☐ Circulation problems	☐ Hepatitis A/B/C	☐ Mitral valve prolapsed	☐ NONE
☐ Congenital heart lesions	☐ Herpes	☐ Organ transplant/implant	

13. Children Only: Have you recently had any of the following (Approximate date)?

☐ Chicken Pox	☐ Tonsillitis
☐ Strep Throat	☐ Mumps
☐ Measles	☐ NONE

14. What is your reason for today's visit? ☐ Emergency ☐ Examination ☐ Other _____

15. When was your last dental visit? _____

16. Have you ever had local anaesthetic (freezing)? Any Complications ☐ No ☐ Yes - Specify_____

OFFICE FINANCIAL POLICY

This information will explain the policy of our office regarding payment for dental treatment. Please select your method of payment below.

Accounts should be settled in full at the time of service.

☐ Non-Assignment: I am responsible for FULL PAYMENT at the end of each treatment. I understand that insurance is a contract between me, the insurance company, and/or my employer.

☐ Assignment: The dental office will submit a claim directly to my primary & secondary insurance. In addition, I agree to pay all fees not covered by my insurance policy on the day of treatment.

* Assigning your dental benefits directly is an option we offer. Most patients prefer this option so that they are not required to pay for their treatment in entirety. We provide the courtesy of submitting the claim to your Primary & Secondary insurance on your behalf.

*We are a third party to the contract and the insurance companies are not obligated to share your confidential information. There are constant changes being made by your employer and insurance carriers to your coverage, deductibles and annual maximum. These are not being shared with us. Therefore, it is impossible for us to know exactly what is covered. As a courtesy, we will submit an estimate for you; we ask that you please follow up with your insurance to determine your coverage.

Patients with no dental insurance: I am responsible for full payment at the end of each treatment.

Cancellation Policy

For all appointments, we require 2 full working days notice for any cancellations. We prefer to speak directly to you regarding changes to your appointment, therefore we request that you call during regular business hours. The fee for failure to provide notice, (except for extenuating circumstances) is $25.00 for the first occurrence, $50.00 for the second and $100.00 for the third.

Please arrive on time or early for your visit. If you are more than 10 minutes late, we may not be able to complete your appointment.

Delinquent Accounts

After 90 days, all accounts that are not paid in full may be sent to a third party collection agency.

GENERAL RELEASE I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed 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 care provider as is 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 dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. I hereby certify that I have been notified of the privacy policies of this office, who to contact regarding privacy concerns and how to request further information.

_____	_____	_____
Date	Patient Name	Signature of Patient/Parent/Guardian