Welcome to

(Please fill out both sides.)

Confidential Patient Information

Patient Name: ____ ☐ Male ☐ Female
Last First MI

☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date: (DAY / MONTH / YEAR) _______________

Name of Spouse_____________________________ Names of Children ____________________

Phone (Home): ______________ ___(Work): ______________ Ext:_____ Best time to call:__________

Mobile_____________________ Email_______________

Address: ____
Street Apartment #

____
City Province Postal Code

Health Information

Name of Previous Dentist:__________Date of Last Dental Visit: __________Reason for this visit:____________

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV
☐ Allergies __________
____
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma

☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Migraine Headaches
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker

☐ **Pregnancy**
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoking
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy

☐ Penicillin Allergy
Please list your Medications:
____
____
____
____
____
____
____

- Have you ever had any complications following dental treatment? ☐ No ☐ Yes, please explain: _______________
- Have been to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes, please explain: ________
- Are you now under the care of a physician? ☐ No ☐ Yes, please explain:______________________________
- Name of Physician: ______________________________________ Phone:____________________
- Do you have any health problems that need further clarification? :___________________________________

Is there anything else you would like to add to help us make your visits more comfortable?

Referral Information

Whom may we thank for referring you to our practice?
☐Another patient, ____________________________
☐ Shopping in Plaza ☐ Google ☐ Website
☐ Road Sign ☐ Other: _________________________

Special Concerns:

Are you nervous about dental treatment? ☐ no ☐ yes ____________________________
Would you like more information on tooth whitening? ☐ no ☐ yes ____________________________
Would you like more information on braces? ☐ no ☐ yes ____________________________
Are you aware of night time tooth grinding? ☐ no ☐ yes ____________________________
Do you require a sports mouth guard? ☐ no ☐ yes ____________________________

If someone else is responsible for your account please fill out this box,

Name of Person Responsible for Account: ____
☐ Male ☐ Female
Birth Date: ________________ ☐ Married ☐ Single ☐ Child ☐ Other ____________________________
Phone (Home): ________________ (Work): ________________ Ext:______ Best time to call: ______________
Address: ____
Street Apartment #
____
City Province Postal Code

Primary Insurance Plan

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _________________ ID #: ______________________ Group #:______________________
Insured's Address: (if different from patient's Address)
____
Street City Province Postal Code
Insured's Employer Name: ____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________
Insurance Plan Name:____

Secondary Insurance Plan

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _________________ ID #: ______________________ Group #:______________________
Insured's Address: (if different from patient's Address)
____
Street City Province Postal Code
Insured's Employer Name: ____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________
Insurance Plan Name:____

Please initial all applicable items:

___ I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.

___ I hereby assign my benefits payable from claims submitted electronically or by mail to the dentists of Rossland Landing Dental Care and authorize payment directly to him/her.

___ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Financial Policies

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

All estimates for care are approximate.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: _____________ Relationship to Patient:_______________
Signature of patient, parent, guardian, or guarantor of payments

____

Printed Name of patient, parent, guardian, or guarantor of payments