FamilyTreeDental

(Please fill out both sides)

CONFIDENTIAL PATIENT INFORMATION **DATE:** DD / MM / YYYY

Patient Name: _____
Last First MI

☐ Male ☐ Female ☐ 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
☐ 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
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems

☐ Smoking
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease

ALLERGIES:
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Latex Allergy
☐ Other: _____

_____

_____

IF FEMALE:
Y N
☐ ☐ Taking birth control?
☐ ☐ Currently Pregnant?
If yes, no of weeks____
☐ ☐ Currently Nursing?

Please list your Medications:

_____
_____
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ No ☐ Yes, Please explain:_____
- Have you 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? _____

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 _____

We provide patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Receive Text Message Appointment Reminders
- Confirm appointments via Email
- Submit Patient Satisfaction Surveys

You may opt-out of your communications at any time.

INSURANCE HOLDERS INFORMATION

Primary Insurance Plans:

Name of Insured: _____ Is insured a patient? ☐ No ☐ Yes
Last First MI

Insured's Birth Date: (DAY / MONTH / YEAR) _____ID #_____ Group #_____

Insured's Address (if different from patient's Address):

_____
Street Apartment # City Province Postal Code

Insured's Employer Name:_____

Patients' relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name:_____

Secondary Insurance Plans:

Name of Insured: _____ Is insured a patient? ☐ No ☐ Yes
Last First MI

Insured's Birth Date: (DAY / MONTH / YEAR) _____ID #_____ Group #_____

Insured's Address (if different from patient's Address):

_____
Street Apartment # City Province Postal Code

Insured's Employer Name:_____

Patients' 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.

___To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a 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. We will do our best to work with your insurance company and submit claims on your behalf, however we require payment at time of service. Payment plans available on request.

All estimates for care approximate

We require 2 business days' notice for appointment cancellations. A fee will be added to your next appointment in circumstances where sufficient notice is not given.

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