*Welcome to*

***(Please fill out both sides)***

## Confidential Patient Information

Today's Date:(D/M/Y)_____________

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:______ (Mobile): __________________

E-mail: _____________________________________________________________________________________

**How would you prefer to be contacted**? ☐ Phone ☐ Text Message ☐ E-mail

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
☐Latex 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 ☐ Yellow Pages ☐ Road Sign ☐ Google ☐ 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 ☐ Married ☐ Single ☐ Child ☐ Other ____________

Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ Ext:______ Best time to call: __________

Address: ____________________

Street Apartment #

____________________

City Province Postal Code

## Insurance Holder's Information

**Primary Insurance Plans**

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 Plans**

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 Dr. O. Rohn, Dr. A. Ibrahim, Dr. A. Kosteski, Dr. S. Family, Dr. S. Leung, Dr. K. Chen, Dr. N. De Cornejo, Dr. A. Sajan, Dr. I. Shoval, Dr. J. Nikolovski, Dr. J. Hwang, Dr. G. Shahi 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 approximate.

**PIPEDA**

____I acknowledge that I have been shown the office privacy policy and I understand that any information collected about me will be used only for the purposes for which it was collected and will never be shared with a third party without my consent.

___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