COLLINGWOOD DENTAL CENTRE

# Welcome!

Our goal at **Collingwood Dental Centre** is to help you reach and maintain maximum oral health.

You will be provided with an office brochure so that we may better serve you. Thank you for filling out this form completely.

## 1 About You

**FOR OFFICE USE ONLY:** ASA _____

Today's Date: _____

Patient's name: _____ Adult ☐ Child ☐
FIRST LAST MIDDLE INITIAL Male ☐ Female ☐

If child, name of guardian: _____

I like to be called: _____

Home address: _____
STREET APT. #

_____
CITY/TOWN PROVINCE POSTAL CODE

Are other family members patients of our office: Yes ☐ No ☐

If yes, please provide their name(s): _____

Your employer: _____ Occupation: _____

Birthday: _____ Single ☐ Married ☐ Divorced ☐ Widowed ☐
DAY MONTH YEAR

How did you hear about Collingwood Dental Centre? _____

_____

## 2 Dental Insurance

Do you have dental insurance through your employer: Yes ☐ No ☐

If yes, please provide the following information:

Dental insurance company: _____

Group/plan #: _____ Subscriber ID #: _____

Employer name: _____

Do you have other dental insurance coverage: Yes ☐ No ☐

If yes, this coverage is through: Spouse ☐ Parent ☐ Other ☐ _____

Their name: _____ Their birthday: _____
DAY MONTH YEAR

Their employer's name: _____

Dental insurance company: _____

Group/plan #: _____ Subscriber ID #: _____

## 3 Telephone/Email

Home Tel. #: ( ) _____ Work Tel. #: ( ) _____

Cell Tel. #: ( ) _____ Email: _____ @ _____

Can you be reached at work: Yes ☐ No ☐ Best way to contact you? Home ☐ Work ☐ Cell ☐ Email ☐

In the event of an emergency, is there someone who lives near to you that we could contact?

Name: _____ Relationship: _____

Home Tel. #: _____ Work Tel #: _____

# 4 Medical History

Family physician's name: _____ Tel. #: _____

Approximate date of your last visit: _____ Your current physical health is: Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a physician? Yes ☐ No ☐ If yes, please explain: _____

_____

Do you smoke or use tobacco in any other form? Yes ☐ No ☐ Do you require antiobiotic coverage prior to dental treatment? Yes ☐ No ☐

Are you presently taking any drugs prescribed by a physician or dentist? Yes ☐ No ☐

If yes, please list: _____

Have you had any serious medical conditions in the past 5 years? Yes ☐ No ☐ If yes, please explain: _____

_____

Have you ever had any of the following diseases or medical problems?

| | | | |
|---|---|---|---|
| Y N Heart Failure | Y N Stroke | Y N Asthma | Y N Cancer |
| Y N Heart Disease or Attack | Y N Diabetes | Y N Hay Fever | Y N Chronic Cough |
| Y N Angina Pectoris | Y N Glaucoma | Y N Allergies or Hives | Y N Emphysema |
| Y N Congenital Heart Disease | Y N Arthritis | Y N Sinus Trouble | Y N Multiple Myeloma |
| Y N Heart Murmur | Y N Rheumatism | Y N Ulcers | Y N Radiation Therapy |
| Y N High/Low Blood Pressure | Y N Osteoporosis | Y N Blood Transfusion | Y N Chemotherapy |
| Y N Arteriostenosis | Y N Cortisone Medicine | Y N Bruise Easily | Y N Venereal Disease |
| Y N Mitral Valve Prolapse | Y N Thyroid Disease | Y N Bleeding Problems | Y N Malignant Hyperthermia |
| Y N Artificial Heart Valve | Y N Kidney Problems | Y N Hemophilia | Y N Epilepsy or Seizures |
| Y N Heart Pacemaker | Y N Liver Disease | Y N Anemia | Y N Developmentally Disabled |
| Y N Heart Surgery | Y N Paget's Disease | Y N Dental or TMJ Implants | Y N Psychiatric Treatment |
| Y N Fainting or Dizzy Spells | Y N Hepatitis A, B, C, D, E or F | Y N Artificial Joints (ex. Hip, Knee) | Y N Drug Addiction |
| Y N Rheumatic Fever | Y N Tuberculosis (TB) | Y N Cosmetic Surgery | Y N Nervousness |
| | | | Y N AIDS or HIV Positive |

Any other serious medical conditions: _____

Have you experienced any that are not listed above? Yes ☐ No ☐ If yes, please list: _____

_____

Are you allergic to or have you ever reacted to any of the following?

| | | | | |
|---|---|---|---|---|
| Y N Aspirin | Y N Percodan | Y N Sleeping Pills | Y N Erythromycin | Y N Metals (ex. Nickel) |
| Y N Local Anesthetic | Y N Nitrous Oxide | Y N Valium | Y N Tetracycline | Y N Latex |
| Y N Clindamycin | Y N Darvon | Y N Other Antibiotics | Y N Demerol | |
| Y N Penicillin | Y N Codeine | Y N Cephalosporins | Y N Sulpha Drugs | |

For women: Are you pregnant? Yes ☐ No ☐ Week #: _____

1. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
2. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
3. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance as required to provide proper care.
4. I agree to the use of local anesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
5. Payment is due in full on date of service with the following payment options: CASH, VISA, MASTERCARD, INTERAC

   Our office is equipped to submit insurance claims electronically if we have your correct information. (Note: Not all insurance companies do electronic claims.)

   The account holder will be responsible for all interest (18% ARP or 1.5% per month) on overdue accounts. Accounts in default will be subject to further administration costs. NSF payments are subject to a $40.00 fee.

   PLEASE DO NOT HESITATE TO ASK OUR STAFF SHOULD YOU HAVE ANY QUESTIONS REGARDING PAYMENT.
6. Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it will be necessary to charge for time lost.
7. I authorize release, to my dental benefits plan administrator & the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the name dentist. This authorization will continue in effect until the undersigned revokes the same.

I UNDERSTAND AND AGREE TO THE POLICIES LISTED ABOVE.

Patient's Name: _____ Dentist: _____

Parent/Guardian's Name: _____ Relationship to Patient: _____

Signature of Patient, Parent or Guardian: _____ Date: _____