172 Prince William Way, Unit 10 Barrie, ON | (705) 721-9229 |
http://www.princewilliamway.com.

Insurance Information Request

Insurance Company: ____

Employer: ____

Policy/Contract #: ____

Member id #(certificate/employee/SIN):

____

Member's (owner of policy) Date of Birth:

____

Claimant's (patient) Date of Birth:

____

Claimant's first name: ____

Claimant's last name: ____

Claimant's relationship to member (child/spouse) :

____

Welcome To Our Dental Office

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION ON BOTH SIDES.

PERSONAL INFORMATION Date ______________________________
Day Month Year

Name ____ Address

___________________________________ Date of Birth ______________ Age ____ City

______________________________________ Home Phone ______________________ Postal Code

________________________________ Office Phone ______________ Ext. ____ Occupation

________________________________ Title: Mr. / Miss / Mrs. / Ms.

Name of Employer ___________________________ Medical Doctor

______________________ Email _____________________________________

Name of person responsible for this account ____

Do you have dental insurance? ____

Company Name ____

Policy No. _________________________________

% Covered _________________________

I.D. or S.I.N. No.

____

How did you hear about our practice?

____

MEDICAL HISTORY

	Yes	No
1. Have you ever had a serious illness, operation, or been hospitalized? If Yes, explain ____	☐	☐
2. Are you under the care of a physician now for any problem? If Yes, explain ____	☐	☐
3. Have you had a medical examination within the last year? If Yes, explain ____	☐	☐
4. Have you taken any medicines, drugs or pills presently? If Yes, explain ____	☐	☐
5. Have you ever taken or been given bisphosphonate medication or any of its family?	☐	☐

6. Do you have or have you ever had any of the following? (Circle)

Rheumatic Fever	Liver Disease (Jaundice, Hepatitis)	Thyroid
Heart Trouble	Kidney Disease	Disease
High Blood Pressure	Diabetes	Lung Disease
Heart Murmur	Epilepsy	Asthma
Venereal Disease	Radiation or X-ray Disease	Blood
Mental or Nervous Disease	Gastrointestinal Disease	Disorders
Joint Replacement	AIDS	Anemia
		Cancer
		Sinusitis

Other ____

7. Do you have any allergies?
If Yes, explain ____

8. Are you allergic to any medicines or drugs?
If Yes, explain ____

Yes No

9. Have you ever had freezing (local anaesthetic) in your mouth?
Any ill effects from it? ____
10. Do you bleed abnormally?
11. Do you bruise easily?
12. Have you ever fainted? When? ___________________________________
13. Do you have shortness of breath?
14. Do you have any chest pains?
15. Do your ankles ever swell?
16. Have you gained or lost excessive weight recently?
17. Have you ever taken cortisone or steroids?
18. Is there any history of family disease?
19. Is there anything that the dentist should know regarding your medical history that has not been mentioned?
Explain ____
20. To the best of your knowledge, are you in good health?
WOMEN: Are you pregnant?
If yes, in what stage of pregnancy?__________________________

DENTAL HISTORY

1. Have you ever had a complete dental examination with a full series of dental x-rays within the past 3 years?
2. Last dental visit? _________ What was done? ______________________
3. Have you had any extractions?
If yes, did you experience prolonged bleeding after?
4. Have you ever had any of the following dental treatments? (Circle)

Root Canal Orthodontics Full or partial denture Periodontal (gums) Crowns or Caps Bridgework

5. Are you aware of bad breath or a bad taste in your mouth?
6. Have you ever had a bad experience at the dentist?
7. What is your present dental problem?
____

Dentist Signature _________________________ Date _____________

PATIENT/GUARDIAN APPROVAL AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

I also consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume the responsibility for fees associated with these procedures.

Signature ____ Date ______________

Prince William Way Dentistry
170 Prince William Way, Unit 10
Barrie, Ontario
Office: 705-721-9229 Fax: 705-721-6671
Email: info@princewilliamwaydental.com

Date: ______________________

To Whom It May Concern:

I, ____, give authorization for (previous dentist name)____, to release all dental records to Prince William Way Dentistry for the following patients:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

_____________________________________ _____________________________________

Please email digital x-rays to the email provided above, and provide the following information:

Last New Patient Exam: _________________________

Last Recall Exam: _________________________

Last Bitewing x-rays: _________________________

Last Panoramic x-ray: _________________________

Last FMS: _________________________

Thank you for your co-operation. If you have any questions or concerns, please do not hesitate to contact us via our office number or email.

Sincerely,
Dr. P Jadidi and Dr. M Jadidi

New Patient Office Policy Agreement

I consent to this office, Prince William Way Family Dentistry, to collect, use and disclose information about me for the following purposes:

Patient Care:

- To assess your health needs and to deliver safe, efficient patient care
- To ensure continuously high quality services
- To advice you of treatment options
- To offer and provide treatment, care and services in relationship to the oral and maxillofacial complex, and general dental care
- To allow is to efficiently follow-up for treatment, care and billing

Initial: _____ Staying in Contact:

- To enable us to contact you
- To establish and maintain communication with you to distribute health-care information, and to book and confirm appointments

Initial: _____

Insurance Claims and Submissions:

- To complete and submit electronic and/or paper dental claims for third party adjudication, pre-approval where necessary
- I authorize the release of my Dental Benefits Plan information, contained in claims and estimates submitted electronically, or by mail. This authorization shall continue to be in effect until contractually terminated by the account holder

Initial: _____ Patient Account:

- To send invoices for goods and services
- To process payments
- If patient accounts fall into arrears, all reasonable collection fees will be the responsibility of the patient, in addition to the arrears

Initial: _____ Privacy:

- For teaching and demonstrating the purposes on an anonymous basis
- To permit potential Dentists, practice brokers, and/or advisors to evaluate the dental practice and conduct an audit

Initial: _____

Cancelled, Missed, or Rescheduled Appointments:

- I am aware that there may be a $50.00 charge when cancelling/rescheduling an appointment with less than 2 (two) business days notice.
- I am aware that there may be a $50.00 charge when an appointment is missed.

Initial: _____

Patient Signature: ______________________________________

Date: _________________________________

Prince William Way Dentistry
10-172 Prince William Way
Barrie, Ontario
Office: 705-737-9229
Fax: 705-721-6671
Email: info@princewilliamwaydental.com

Date: ___________________________

To Whom It May Concern:

I, ____, give authorization for (previous dentist name) ____, to release all dental records to Prince William Way Dentistry for the above patient name listed and/or the following patients.

____ ____

____ ____

____ ____

Signature: ____

Please email digital x-rays to the email provided above, and provide the following information:

Last COE	Last RC	Last PAN	Last FMS	Last BWS

Thank you for your co-operation. If you have any questions or concerns, please do not hesitate to contact us via our office number or email.

Sincerely,

Dr. P Jadidi and Dr. M Jadidi