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: _____

Signature: _____ Date _____

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: _____

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) :

_____