##

# NEW PATIENT FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| PATIENT INFORMATION

|  |  |  |
| --- | --- | --- |
| Last Name:  |  First Name:  |  |
| Preferred Pronoun: |  Nickname: |  |
| Birth date: |  | Occupation: | Employer: |  |

Address: City: Province: Postal Code:

|  |  |  |
| --- | --- | --- |
| Phone no.: | Email: |  |
| Emergency Contact Name: |  | Emergency Contact Number: |
| How would you like your appointments confirmed by? Check all apply.  | * Phone
* Email
* Text
 |  |

How did you hear about us?

|  |  |  |  |
| --- | --- | --- | --- |
|[ ]  Google Search |[ ]  Google Review |[ ]  Mailouts |[ ]  Signage |
|[ ]  Word of Mouth |[ ]  Event |[ ]  Social Media |[ ]  In the Area |

If Word of Mouth, who referred you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other family members seen here:INSURANCE INFORMATION(please give your insurance card to the receptionist.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| INSURANCE #1Subscribers Name: | Policy Holder’s Birth date: | Member ID: | Carrier: | Group/Policy Number.: |
| INSURANCE #2 (if applicable) Subscribers Name: |  Policy Holder’s Birth  date: | Member ID: | Carrier: | Group/Policy Number.: |
| Billing - Dental Choice offers the following payment options. Please choose which option you would like to participate in.Option 1 – This requires you to pay in full the day of treatment. We accept VISA, MasterCard, Cash, and Debit. Our dental administrative staff will assist you with preparing and submitting claims to your insurance if necessary.Option 2 – This option allows your insurance to be billed directly and any outstanding amounts not covered are the responsibility of the patient and will be collect the day of service. For this option please fill out the required information below. | I agree to the financial responsibility for any amounts not covered by my dental insurance to be applied to the credit card:Credit Card (circle one): VISA M/C Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry: \_\_\_\_\_Name on Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3-digit v-code: \_\_\_\_Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date:\_\_\_\_\_\_\_\_\_\_I consent to oral and dental procedures agreed to be necessary or advisable and will take responsibility for fees associated with those procedures.  |
| IMPORTANT: Office Cancellation PolicyDue to high demand in prime appointments, we require a minimum of 2 business days per appointment to cancel or reschedule. If insufficient notice is given, a $100 charge will be applied to your account and must be paid in order to schedule future appointments. |

MEDICAL HISTORYPlease check off any of the following conditions you have had (all information remains confidential):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| * Diabetes
* Heart Condition
* Shortness of Breath
* Liver Disease
 | * HIV/AIDS
* Thyroid Disease
* Anxiety
* Depression
* Fainting/Seizures
* Osteoporosis
 | * Asthma
* Stroke
* Cancer/Tumors
* Autoimmune Disorder
* Chest Pains
* Lung Disease
 | * Kidney Disease
* Arthritis
* Jaundice
* Hepatitis A,B,C
* Ulcers
* High Blood Pressure
 | * Low Blood Pressure
* Rheumatic Fever
* Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 1. Are you pregnant? If so, which trimester: \_\_\_\_\_\_\_\_\_\_\_Are you breastfeeding? YES NO
2. Are you under the care of a physician for a specific chronic condition? YES NO If so please specify: Date of last check up:
3. Have you had any major surgeries in the last 2 years? Please list:
4. Do you smoke or chew tobacco products? YES NO
5. Do you smoke or use by-products of Cannabis?

YES NO 1. Drug allergies, reactions and/or injections? Please list:
2. Are you currently taking ANY medications? Please list:

1. Do you have a prosthetic or artificial joint Please list:
2. Rate your smile from 1-10 (10 being the highest)
3. How would you rate yourself as a dental patient?
* Calm
* Somewhat Anxious
* Very Anxious
 | DENTAL HISTORYHave you ever had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes noWhen was your last dental examination and cleaning?When were your last dental x-rays taken?Have you noticed any signs of the following?* Bleeding/Swelling of Gums
* Gum Ache
* Receding Gums
* Loose Teeth
* Drifting Teeth
* Bad Breath
* Sensitivity of Teeth
* Dry Mouth
* Jaw Pain/Noise

What is the one most important concern to you regarding dentistry? * Cost
* Time
* Appearance
* Discomfort
* Other: \_\_\_\_\_\_\_\_\_\_

Are you interested in * Sedation
* Invisalign
* Other: \_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s Date:\_\_\_\_\_\_\_\_\_\_I consent that all the information stated above is correct and filled out to best of my knowledge.  |
| FOR MORE INFORMATION VISIT: WWW.DENTALCHOICE.CA |  |

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