GET ACQUAINTED QUESTIONNAIRE

PERSONAL INFORMATION

MEDICAL-DENTAL ALERTS_____

Today's Date _____ _____ _____
Day Mo. Yr.

Name _____ **Date of Birth** _____ _____ _____
Day Mo. Yr.

Home Address _____ **Apt. #** _____

City _____ **Province**_____ **Postal Code**_____

Telephone #'s Home: _____ **Work:** _____ **Cell:** _____

Email address _____
MAY WE USE YOUR EMAIL FOR APPOINMENT REMINDERS AND INVOICES? **YES** ☐ **NO** ☐

Place of Employment _____ **Occupation**_____

Marital Status _____ **Name of Spouse**_____

INSURANCE INFORMATION

Name of person responsible for account _____

Do you have dental insurance? _____ **Insurance Company Name**_____

Policy/Group # _____ **ID/Certificate#** _____ **Health Card #** _____ **VC**_____

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and to give the highest possible standard of professional services. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

Are you now under the care of a physician? _____ Yes___No____

If so, what is the condition being treated? _____

Have you had any serious illness or operation / or have you ever been hospitalized?_____ Yes____No____

If so, what is the illness or operation? _____

Are you taking any drug or medicine (prescription or non-prescription) including oral contraceptives?____Yes ____No____

If so, what? _____

Are you allergic or have you reacted adversely to any drug or medicine: e.g. local anaesthetic, Penicillin or other antibiotics; barbiturates, sedatives, analgesics (painkillers)? _____Yes____No____

Do you have any other allergies? If so, what? _____Yes____ No____

Have you ever had abnormal bleeding associated with previous extraction, surgery or trauma? _____Yes____ No____

Are you currently in good health? _____ Yes_____No___

To the best of your knowledge have you ever come in contact with A.I.D.S.?_____ Yes _____No___

Are you pregnant? If so, how many months? _____Yes_____No___

Do you have or have you had any of the following diseases or problems:

Asthma..... Yes_____No_____
Heart Attack..... Yes_____No_____
Heart Surgery..... Yes_____No_____
High Blood Pressure..... Yes_____No_____
Artificial Valve..... Yes_____No_____
Respiratory Problems..... Yes_____No_____
Thyroid Problems..... Yes_____No_____
Rheumatic Fever..... Yes_____No_____
Liver Disease..... Yes_____No_____
Mental Disorder..... Yes_____No_____
Chemotherapy..... Yes_____No_____
Radiation..... Yes_____No_____
Epilepsy..... Yes_____No_____
Other _____

Anaemia..... Yes_____No___
Heart Murmur..... Yes_____No___
Mitral Valve Prolapse..... Yes_____No___
Pacemaker..... Yes_____No___
Stroke..... Yes_____No___
Hip or Knee Replacement..... Yes_____No___
Sinus Problems..... Yes_____No___
Diabetes..... Yes_____No___
Hepatitis, Type..... Yes_____No___
Ulcer..... Yes_____No___
Cancer, what type..... Yes_____No___
Tuberculosis..... Yes_____No___
Seizures..... Yes_____No___

In case of emergency notify _____Telephone _____Relationship _____

Name of Personal Physician _____Telephone _____

Name of Previous Dentist _____Telephone _____

Whom may we thank for referring you to our office? _____

Office Policy/Treatment Consent

It is our office policy that your portion of the services is paid at EACH visit as they are performed. In certain circumstances, payments may be arranged by consulting with your doctor and/or the office manager. As a courtesy to our patients, we will prepare necessary reports to help collect your benefits from the insurance companies. Claims not paid after 4 weeks will be billed to you. Each fee takes into consideration the procedures performed and its difficulty and is not based on the assumption that the insurance company will pay all our charges. Any late payments are subject to an interest penalty of 2% per month.

Electronic Claims Submission

As a participant in electronic claims submission, your insurance claim form may now be sent automatically to your carrier by our computer. Electronic claims submission saves you the effort and cost of mailing the insurance form yourself. As well, your insurer will be able to process your claim faster, which means payment will be received faster than before. If your insurance company is accepting claims electronically, by signing the consent below, we will be of better service to you.

I certify that the information provided above is true. By signing below, I give my consent to obtain or exchange any information about me from my Credit Bureau, Employer or any other person or Organization in connection with the above information.

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anaesthetic as indicated. I fully understand the office policy and I will assume responsibility for fees associated with those procedures performed.

PATIENT'S (PARENT'S) SIGNATURE _____DATE_____

WE REQUIRE 48 HOURS NOTICE IF UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT IN WHICH CASE NO CHARGES WILL APPLY.