NEW PATIENT FORM

We are committed to providing you the most comprehensive care and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better care we can give you. If you have any questions or need assistance, please ask – we would be happy to help!

ABOUT YOU

Last Name_____ First Name_____ Middle Name_____

Preferred Name: _____

Occupation: _____

Home Phone #_____ Work #_____ Cell #_____

Mailing Address: _____ City_____

Province: _____ Postal Code: _____

Date of Birth _____/_____/_____ (Month / Day / Year)

Marital Status: _____ Spouse's Name: _____

MHSC# _____ Personal Registration # _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Preferred Method of Contact: _____ Call _____ Text _____ Email

Appointment Reminder – Do you prefer a phone call or text message? PLEASE CIRCLE

INSURANCE INFORMATION

Name of Policy Holder: _____

Date of Birth (Policy Holder): _____

Name of Insurance Company: _____

Subscriber Group/Plan #: _____Subscriber ID/Certificate #: _____

Place of Employment: _____

Relationship to Policy Holder: _____ Self _____ Spouse _____ Dependent

Are you claiming through more than one insurance? _____ YES _____ NO

If so, please complete the next section.

SECONDARY INSURANCE INFORMATION

Name of Policy Holder: _____

Date of Birth (Policy Holder): _____

Name of Insurance Company: _____

Subscriber Group/Plan #: _____Subscriber ID/Certificate #: _____

Place of Employment: _____

Relationship to Policy Holder: _____ Self _____ Spouse _____ Dependent

DENTAL HISTORY

Reason for today's visit: _____ Check-UP _____ Cleaning _____Toothache _____ Other

Date of last visit? _____ What was done? _____

Previous Dentist: _____

Who may we thank for referring you? _____ Internet _____Mail/Advertisement _____Friend/Family

MEDICAL HISTORY

Family Physician: _____ Phone #: _____

Have you been an overnight patient in the hospital in the Last 2 years?	YES	NO
Do you have any allergies? (Penicillin, Aspirin, Codeine or Latex)	YES	NO
Do you have anemia or bleed abnormally?	YES	NO
Do you take any non-prescription medications? (Aspirin/Tylenol)	YES	NO
Do you take prescriptions medications?	YES	NO

List of medications: _____

WOMEN: Are you currently pregnant? YES NO

Have you ever had any of the following diseases or conditions, either previously or at present time? Please check all that apply:

Diabetes	Asthma	Cancer
Epilepsy	Emphysema	Hepatitis A, B or C
Jaundice	Ulcers	High/Low Blood Pressure
Kidney Disease	Pacemaker	Rheumatic Fever
Blood Transfusion	Sinus Trouble	Stroke
Heart Murmur	Bruise Easily	Heart Problems (disease/attack)
MS	Latex Allergy	Anxiety/Depression
Thyroid Disease	Anemia	Arthritis
Angina	Allergies/Hives	Hay Fever
Persistent Cough	Artificial Joint	HIV Positive/Aids
Nervousness	Rheumatism	Congenital Heart Defect
Heart Surgery	Sleep Apnea	Other _____
Sickle Cell Disease	Mental Illness	

Are there any other medical problems we should be aware of? _____

_____

I, the undersigned, certify that I have provided an accurate and complete medical history and have not knowingly omitted any information. I authorize the dentist to preform procedures and consent to treatment and I will assume responsibility for the fees associated with those procedures/treatment. I authorize the release of my personal information regarding my diagnosis or treatment to my insurance company or any other dental profession.

Signature: _____ **Date:** _____

If under the age of 18 please list parent/guardian: _____

APPOINTMENT POLICY

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us 1 business day (24 hours) notice if they cannot keep an appointment. Appointment changes with less than 24-hour notice are subject to a service fee of $100.00. It is my responsibility to confirm appointments and understand that if I do not confirm my appointment, there is a risk of the appointment being rescheduled. Patients that do not show up for appointments may not be booked again.

INITIALS_____

FINANCIAL POLICY, AUTHORIZATION & CONSENT

Please be advised that ALL first-time appointments or emergency treatment (non-regular patients) will be required to pay after each treatment.

AFTER, the first appointment of regular patients we will accept consignment from your insurance company.

For all patients who do not have dental insurance you are required to pay for treatment the same day at the end of appointment.

For your convenience, our office will direct bill your insurance company, the estimated patient portion will be the balance due at the end of your treatment. We do accept cash, debit, Visa and Mastercard. Dental insurance plans often pay less than the actual fee for the service. Therefore, you are responsible for all costs that the dental insurance plan does not cover. If you would like to know more about your insurance plan (s) and what they cover, please ask and we can help you find out.

I agree and consent to a dental examination and treatment. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done.

I authorize Fieldstone Dental to release any information regarding my dental/medical history, diagnosis, or treatment to third party payors and/or other health professionals.

I authorize Fieldstone Dental to bill my insurance company and understand and comply with all policies.

Signature: _____ **Date:** _____