NEW PATIENT FORM

We are committed to providing the most comprehensive care possible 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: ____

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? _____________________Previous Dentist: ____

What was done? ____

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: ____

Do you smoke/vape/chew tobacco?	YES	NO
Do you wear a night guard?	YES	NO
Do you wear full or partial dentures?	YES	NO
Are you able to chew comfortably?	YES	NO
Have you had orthodontic treatment?	YES	NO
• If so, do you wear retainers?	YES	NO
Are you happy with your smile?	YES	NO
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:

Clenching/grinding	Sleep Apnea	Sinus Trouble
Diabetes	Asthma	Emphysema
Cancer	Epilepsy	Hepatitis A, B or C
Jaundice	Kidney Disease	High/Low Blood Pressure
Sickle Cell Disease	Blood Transfusion	Stroke
Eating Disorder	Multiple Sclerosis	Mental Illness/Depression/Anxiety
Thyroid Disease	Anemia	Artificial Joint
Arthritis	Allergies/Hives	HIV Positive/Aids
Rheumatic Fever	Osteoporosis	Kidney Disease
Heart Murmur	Pacemaker	Congenital Heart Defect
Heart Surgery (bypass, stent etc)		Angina

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

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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. 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. **INITIALS________**

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 48-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.

FINANCIAL POLICY, AUTHORIZATION & CONSENT

All patients are required to pay for treatment the same day at the end of appointment.

Should you have insurance, our office will direct bill your insurance company, leaving the estimated patient portion to be paid at the end of your treatment. The patient will be 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.

We do accept cash, debit, Visa and Mastercard. Dental insurance plans often pay less than the actual fee for the service.

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 completion.

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

Signature: ______________________________________ **Date:** ____________________________________