



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 _____

Previous Dentist: _____ Date of last visit with your 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 use any form of nicotine, cannabis or street drugs? 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	GERD	Kidney Disease
Heart Murmur	Pacemaker	Congenital Heart Defect
Heart Surgery (bypass, stent etc)		Angina
Osteoporosis/Osteopenia (T-score known?)		

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 perform 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 2 business day (48 hours) notice if they cannot keep an appointment. Appointment changes with less than 2 business days (48 hours) 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's portion to be paid at the end of your treatment. **The patients 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 submit a pre-determination. It is ultimately the patient responsibility to know and understand their insurance benefits.

We do accept cash, debit, Visa, Mastercard and e-transfer. Dental insurance plans often do not pay the full current Manitoba fee guide and patients are responsible for the difference at the end of each appointment.

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.

AI Policy

This practice may use AI tools to assist in documentation and communication. No diagnostic decisions will be made by AI. All care is supervised and reviewed by a licensed clinician.

Signature: _____

Date: _____