

NEW PATIENT INFORMATION

First Name _____ Last Name _____ Date of Birth _____ Preferred Pronoun _____
Address _____ City _____ Province _____ Postal Code _____
Phone Number _____ Email _____

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____
How did you hear about our office? _____ What are your primary dental concerns? _____
When and where was your last dental visit? _____

PATIENT DENTAL HISTORY

- Do your gums bleed while brushing or flossing? Yes No
- Are your teeth sensitive to hot, cold or sweets? Yes No
- Do you feel pain to any of your teeth? Yes No
- Have you noticed any loose teeth? Yes No
- Do you have any missing teeth? Yes No
- Have you had any head, neck or jaw injuries? Yes No
- Do you notice any wear on your teeth? Yes No
- Have you experienced any pain in jaw or near your ears? Yes No
- Do you wear any sort of nighttime appliance? Yes No
- Have you ever had orthodontic treatment? Yes No
- Are you interested in straightening your teeth? Yes No
- Are you interested in whitening? Yes No
- Have you ever had any complications with previous dental treatments? Yes No
- Have you had an unpleasant dental experience? Yes No
- Are you nervous during dental treatment? Yes No
- Are you interested in sedation dentistry? Yes No

MEDICAL HISTORY

At our practice, we take a whole-body approach to dental care. Your mouth is an important part of your overall health, and many medical conditions, medications, and lifestyle factors can impact your oral health — just as oral health can affect the rest of your body. By understanding your full medical history, we can provide care that supports not just your teeth and gums, but your total well-being

Your information is always kept strictly confidential and used only to provide you with the safest, most effective care possible.

FAMILY PHYSICIAN INFORMATION

Name _____ Phone _____

Are you currently being treated for any medical condition? Yes No

If yes, please describe _____

Are you taking any medications, non-prescription drugs or herbal supplements? Yes No

if yes please list them including dosage and what they are prescribed for _____

Do you have any allergies? Yes No

If yes, what are they? _____

MEDICAL QUESTIONNAIRE

Have you been recommended to take antibiotics before dental treatment? Yes No

Do you have a prosthetic or artificial joint? Yes No

Do you have or have you ever had an artificial valve? Yes No

Do you have or had any heart or blood pressure problems? Yes No

Do you have or had congenital heart disease? Yes No

Have you ever had bacterial endocarditis? Yes No

Do you have or had asthma? Yes No

Do you have a bleeding problem or disorder? Yes No

Do you have any condition that could affect your immune system? Yes No

Do you have or have you ever had any of the following? (check all that apply)

- | | | |
|-----------------------------------------------|-------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Osteoporosis | |

Do you have any condition that is not listed? Yes No If yes, please describe _____

FOR WOMEN ONLY

Pregnant? Yes No

Nursing? Yes No

COMPREHENSIVE QUESTIONNAIRE

As part of our whole-body approach to dental care, this questionnaire is designed to give us a deeper understanding of your overall health. Oral health is closely linked to many systemic conditions, including airway and breathing disorders (such as sleep apnea), temporomandibular joint (TMJ) dysfunction, cardiovascular health, diabetes, and more. In addition to your medical and dental history, we include questions related to sleep quality, jaw function, posture, nutrition, stress, and lifestyle habits.

By evaluating the connection between the mouth and the rest of the body, we can deliver more precise, preventive, and personalized care.

Do you experience any of the following:

Daytime fatigue Yes No

Difficulty falling/staying asleep Yes No

Dry mouth or lips Yes No

Snoring Yes No

Feeling unrefreshed upon waking Yes No

Frequent waking throughout sleep Yes No

Gagging easily Yes No

CPAP intolerance Yes No

Ear congestion or trouble hearing Yes No

Headaches Yes No

Jaw clicking/popping Yes No

Jaw locking Yes No

Limited mouth opening Yes No

Pain when chewing Yes No

DENTAL INSURANCE AND PAYMENT

Do you have insurance? Yes No

Do you have secondary insurance? Yes No

Policy holder's name _____

Policy holder's name _____

Policy holder's DOB _____

Policy holder's DOB _____

Name of Ins. Co. _____

Name of Ins. Co. _____

Group/Policy # _____

Group/Policy # _____

Member ID _____

Member ID _____

Employer _____

Employer _____

PAYMENT OPTIONS (Please select one)

Option 1 - Pay in Full at Time of Service

You agree to pay the full cost of treatment on the day of service. We are happy to assist you in submitting your claim to your insurance provider for reimbursement.

Option 2 - Direct Insurance Billing

We will bill your insurance directly. Any amounts not covered by your insurance are your responsibility and must be paid on the day of service.

Credit Card Information

(Optional – if you would like us to handle your balance for you)

First Name _____ Last Name _____

Card Type Visa Amex Mastercard

Credit Card Number _____ Security Code (CVV) _____

Expiration Date (mm/yyyy) _____

_____, I consent to the financial responsibility for any amounts not covered by my dental insurance for the dental treatments provided, and consent us to charge your credit card on file.

Signature _____ Date _____

PATIENT PRIVACY CONSENT

Consent For Release Of Patient Information

We are committed to protecting the privacy of our patients' personal information and to utilizing personal information in a professional and responsible manner. This document summarizes some of the personal information that we collect, use, and disclose. In addition to the circumstances in this form, we also collect, use, and disclose personal information when permitted or required by the law.

We collect information from our patients such as names, home address, work address, home/cellular telephone numbers, work telephone numbers, and email addresses. (Collectively referred to as "Contact Information"). Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health parties or insurance companies.
- To send reminders to patients concerning the need for further examination or treatment.
- To send patients informational material about our office, dental materials, or services offered.
- To follow up with treatment and/or customer service.

How We Collect And Disclose Your Patient Information

Contact information is disclosed to insurance companies, third-party health benefit providers where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment and has authorized us to submit a claim on their behalf. Financial information may be collected to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information"). Patients' medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Patients' medical information is disclosed for the following purposes:

- To third-party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment, or the patient has asked us to submit a claim on their behalf.
- To other dentists and dental specialists, where seeking a second opinion and the patient has consented to seek a second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To the other health care professionals such as physicians if the patient, with their consent, has been referred to us by the other health care professional for either a second opinion or treatment

Note: Dentists are regulated by the local Dental Association and College, which may inspect our records and interview our staff as part of regulatory activities in the public interest.

Cancellations & Missed Appointments

We try very hard to accommodate your schedules when booking appointments. This time is reserved just for you and has been scheduled by you. In order to give you the best care possible and to be fair to all our patients and to our team, we ask that you make every effort to keep these appointments.

If you are unable to keep your appointment, we ask that you give us at least **two business days' notice**. Otherwise, a fee of **\$75.00** will apply.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal, medical, and dental history, and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorize the dentist to perform all diagnostic procedures, including and not limited to x-rays and photographs, that may be required to determine necessary treatment, and to perform necessary or advisable treatment.

I understand that information provided from or to my medical doctor or another healthcare provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used, and disclosed within the guidelines of the policy. I understand that my dental insurance may not cover entirely the total fee of services provided. I understand that I am responsible for payment of the dental services for myself and my dependents, and I assume responsibility for fees associated with these services.

Print Name of Signing Person _____ Email of Signing Person _____

Signature _____ Date _____

This form was signed by Patient Parent Spouse Guardian Other

If other please explain _____