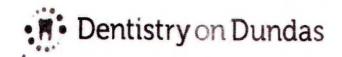
PLEASE FILL IN ALL FIELDS

PATIENT, INFORMATION A Parent or Guardian will be responsible for or	decisions relating my treatment YES NO
Name:	
	Last
	Work Tel:
Address:	
Street Preferred method of contact: Home # Work # Cell # C	Postal Code Text Email
I agree to be added to your Facebook page	l agree to subscribe to your newsletter
Preferred time and day for appointment (check all that apply) Morning	Afternoon Evening
☐ Monday ☐ Wednesday ☐ Friday ☐ Tuesday ☐ Saturday	☐ Sunday
Family Dr:	Tel:
Emergency Contact:	Tel:
How did you hear about us? Referred by (Insert name) Bus Shelters Convenient location www.tridont.com Patient Mobile Sign Google/Search Engine Web Marketing	Family Doctor Advertising around Shoppers World Mal Online Review Other (specify)
INSURANCE INFORMATION Do you have extended health or dental insurance? If yes, please provide your card to receptionist, they will make a copy for your card.	
1. What is the reason for today's visit?	
2. When was your last dental visit?	
3. Are your teeth sensitive to: Cold Sweets H	leat Other
	Never YES NO
5. Do your gums feel swollen or tender?	
6. Do you have bad breath or a bad taste in your mouth?	
7. Do you have food catch between your teeth?	
8. Have you ever had local anaesthetic (freezing)	
Have you had any problems with previous dental treatments? Specify_	
	crowns or Caps Periodontal (Gums) Root Canal
11. Are you satisfied with your teeth?	
12. Do you have Sleep Apnea? CPAP machine	Oral Appliance
	(Continued on reverse side

MEDICAL HISTORY (this informa	tion will remain confidential)		YES	NO
Are you presently under the care of a physician? If so explain				&
2. Have you ever had a serious illn				
3. Are you taking any Drugs or me	dication at this time?			
, , , ,				
4. Do you suffer from any allergies	(hay fever, latex, etc.)? If so which ones?			
5. Do you bruise easily or have pro	olonged bleeding?			
6. Have you ever fainted, had sho	tness of breath or chest pains			
7. Have you ever been warned aga	ainst using any medication? If so which?			
8. Have you ever taken prolonged	medical or non-medical drugs? Specify		□	
9. Have you ever had an adverse e Aspirin Codeine Antibiotics:	☐ Barbiturates (sleeping pills) ☐ Darvon ☐ Local	Anaesthetic namide		
10. Women:			YES	NO
Have you reached monopause?			—	H
Are you taking hirth control?			-	H
A.I.D.S. Cancer Anemia Circulation Angina pectoris Congenita Anorexia nervosa Cortisone/ Arthritis/rheumatism Diabetes	Problems	Opriate circles) Jaundice) Kidney disease) Liver disease) Leukemia) Lung disease) Malignant hyperthermia) Mental/nervous disorder) Mitral valve prolapsed) Organ transplant/implant) Psychiatric treatment) Radiation/Chemotherapy	Rheumatic/S Sickle cell dis Sinus Trouble Stomach/inte Stroke Thyroid disea Tubercusis Ullcers Venereal dise Other None	sease e estinal prob.
Chicken Pox Strep Throat	tly had any of the following (approximate da	ps	edical history	portion of
this chart is important to my treatme consent to the release of medical info authorize this dental office to perfore	nt. I certify that all the information is correct and ormation from my medical doctor or other health in diagnostic procedures as may be required to d dental treatment for both myself and my depend	d that I have not knowingl n provider as required by etermine necessary treat	y omitted da this dental of ment. I under	ta. I fice. I rstand
Signature Patient Parent Gua	rdian Print Name	Date		
DDS Signature	DDS Print Name	Date		***************************************



DENTAL OFFICE POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

General:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation **48 hours** in advance, you will be charged **\$50.00**. Please help us service you better by keeping scheduled appointments.

INSURANCE:

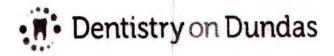
Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

• I hereby assign my benefits, payable from claims submitted electronically, to <u>Dentistry on Dundas</u>, and authorize payment directly to the office. This authorization shall continue in effect until the undersigned revokes the same.

(Continued on reverse side)



		surance benefits apply, ES time of service, unless oth	
* *		oonsible for payment of c ry of the monies due on t	
I have read, understand	and agree to the terms	and conditions of this Fin	ancial Agreement.
Patient Name:			
Signature:		Date:	fit de la como de la c