ProActive DENTAL STUDIO

#100 – 15225 104th Avenue Surrey, BC V3R 6Y8
Phone: 604.583.4242 • www.proactivedentalstudio.com

PATIENT INFORMATION

LAST NAME: **FIRST NAME:**

PREFERRED NAME / NICKNAME:

☐ **MALE** ☐ **FEMALE** ☐ **MARRIED** ☐ **SINGLE** ☐ **CHILD** ☐ **OTHER** **DATE OF BIRTH: (DD/MM/YY)**

ADDRESS: **UNIT/SUITE:**

CITY: **PROV:** **POSTAL CODE:**

PHONE(HOME): **WORK:** **EXT:** **CELL PHONE:**

E-MAIL: **HOW DID YOU HEAR ABOUT US?**

HEALTH INFORMATION

Have you ever had any of the following? Please read carefully. Circle ◯ and/or check ✓ if yes:

☐ Allergies i.e: Penicillin, latex _____	☐ Diabetes	☐ Heart Disease	☐ Nervous Disorders	☐ Stomach Problems
☐ Anemia	☐ Dizziness / Fainting	☐ Heart Murmur	☐ Pacemaker	☐ Stroke
☐ Arthritis	☐ Emphysema	☐ Hepatitis A / B / C	☐ Radiation Treatment	☐ Thyroid Hyper / Hypo
☐ Artificial Joints	☐ Epilepsy	☐ HIV / AIDS	☐ Respiratory Problems	☐ TMJ
☐ Asthma	☐ Excessive Bleeding / Bruising	☐ Hives	☐ Rheumatic Fever	☐ Tuberculosis
☐ Blood Disease	☐ Gastro-Intestinal	☐ Jaundice	☐ Rheumatism	☐ Tumors
☐ Blood Pressure High / Low	☐ Glaucoma	☐ Kidney Disease	☐ Rheumatoid Arthritis	☐ Ulcers
☐ Cancer	☐ Hard To Freeze	☐ Liver Disease	☐ Sinus Problems	☐ Are You Pregnant?
☐ Change of Medication	☐ Hay Fever	☐ Mental Disorders	☐ Skin Rash	Due Date:
	☐ Head Injury	☐ Multiple Sclerosis	☐ STD	OTHER: _____

Are you currently taking any medications or non-prescription drugs of any kind?

If yes, please list _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian **Date**

DENTAL HISTORY

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior dental office or dentist's name/ address/ phone number:

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 – 6 weekly ○ 1 – 6 monthly ○ Seldom ○ Never

Please mark ✓ any of the following to indicate **Yes** in response to the question:

- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, partials?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

RESPONSIBLE PARTY INFORMATION

☐ PARENT / GUARDIAN ☐ SELF

PARENT / GUARDIAN NAME: DOB: (DD/MM/YY)

ADDRESS:

CITY: PROV: POSTAL CODE:

PHONE(HOME): WORK: EXT: CELL PHONE:

DENTAL INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: **(Primary)**

EMPLOYER NAME:

NAME OF INSURED: DOB: (DD/MM/YY)

GROUP / PLAN NO: ID / CERTIFICATE NO:

NAME OF INSURANCE COMPANY: **(Secondary)**

EMPLOYER NAME:

NAME OF INSURED: DOB: (DD/MM/YY)

GROUP / PLAN NO: ID / CERTIFICATE NO:

CONSENT FOR SERVICES AND FINANCIAL POLICIES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursements from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Payment is required for services rendered at the end of each and every appointment. **We accept Interac, Visa and MasterCard and personal cheques (with photo I.D.) NSF charge is $15. NO CASH PAYMENT.**

We accept assignment of insurance benefits. For major dental work we require full co-payment at the time of your first appointment.

It is the patients' responsibility to track their annual insurance limits and to inform us of any changes. Your dental plan is a contract between you and your insurance carrier. Upon their interpretation of the new privacy of information act, many insurance carriers will not give us information about your dental benefits. As a result, it is difficult to accurately determine what the out of pocket costs for our services will be and the patient is ultimately responsible for payment for services not covered by the insurance company.

Please be advised that we **DO NOT** place amalgam fillings. As some insurance plans only reimburse up to the cost of the amalgam fillings, it is the patients' responsibility to cover the balance owing.

We require 2 working days notice to make any changes to your appointment in order to avoid the cancellation/no-show charge.

I authorize the dentist to submit my claim electronically to my insurance company so that the payment will be received in a timely manner.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental assessment and care. Where applicable, I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist or specialist.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian **Date** **Relationship to patient**