ProActive
Dental Studio

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

PATIENT INFORMATION

NAME: DOB: (DD/MM/YY)

☐ MALE ☐ FEMALE ☐ MARRIED ☐ SINGLE ☐ CHILD ☐ OTHER

ADDRESS:

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 and check if yes:

☐ AIDS	☐ Cancer	☐ Hay Fever	☐ Liver Disease	☐ Tumors
☐ Allergies i.e. latex _____	☐ Diabetes	☐ Head Injuries	☐ Mental Disorders	☐ Ulcers
	☐ Dizziness	☐ Heart Disease	☐ Nervous Disorder	☐ Venereal Disease
☐ Anemia	☐ Epilepsy	☐ Heart Murmur	☐ Pacemaker	☐ Codeine Allergy
☐ Arthritis	☐ Excessing Bleeding	☐ Hepatitis A B C	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Artificial Joints	☐ Fainting	☐ High Blood Pressure	☐ Respiratory Problems	☐ Sulfa Allergy
☐ Asthma	☐ Glaucoma	☐ Joint Replacement	☐ Rheumatic Fever	☐ Are you pregnant?
☐ Blood Disease	☐ Growths	☐ Kidney Disease	☐ Rheumatism	Due Date:
☐ Fibromyalgia	☐ Sinus Problems	☐ Stroke	☐ Tuberculosis	OTHER: _____

Date of last dental visit: _____ Reason for today's visit: _____

Date of last professional teeth cleaning: _____

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**

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 cash, Interac, Visa and MasterCard and personal cheques (with photo I.D.) NSF charge is $15.

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**