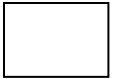


WELCOME TO OUR DENTAL OFFICE



Receptionist

Name: _____

Birth Date:

Sex: M F

(please circle)

Student Single Married Divorced Widow

Child: Guardian Name: _____

Preferred Name: _____

Tel (Home): _____ Cell: _____

Address: _____

Tel (Work): _____

City: _____

May we call you at work? YES NO

Postal code: _____

Employer/Occupation: _____

Health Card # _____

Email Address: _____

Would you like to OPT-IN with us to receive emails and/or text messages for booking/confirming appointments and Bridgeview Dental promotions? You may unsubscribe at any time by speaking to us or updating your contact preferences via our automated Demandforce system. Circle Choice: YES NO

Pharmacy Used: _____

Pharmacy Tel: _____

Next of Kin: _____

Tel (H): _____

Tel (W): _____

How did you hear about us? _____

Dental Insurance: YES NO Insurance Company: _____

Primary Insurance Holder (PIH): _____

Birth Date of PIH:

Policy #: _____ Certificate #: _____

Are you covered under another insurance plan? _____ Would you like us to 'Direct Bill' your insurance provider? YES NO

Direct Billing is a courtesy we offer to our patients. **In order to 'Direct Bill' your insurance provider, we require a credit card on file for outstanding amounts owing after your insurance provider has paid their portion.** Notice will not be given when your credit card is billed. I hereby agree to authorize Bridgeview Dental to apply any outstanding balance on my account, not covered by the insurance provider, to the credit card listed below:

PAYMENT OPTIONS

VISA MASTERCARD AMEX

Card #: _____ Expiry Date: _____

Card Holder's Name: _____ Authorized Signature: _____

If you do not provide a credit card number or you choose to forgo the 'Direct Billing' option, you must pay the full amount owing at the time of your appointment. We will submit the claim to your insurance and you will be reimbursed by your insurance provider directly.

MEDICAL HISTORY

Family Doctor's Name: _____

Tel #: _____

Are you being treated for any medical condition at present? YES NO

If yes, please list: _____

Have you recently, or are you taking any PRESCRIPTION or NON-PRESCRIPTION drugs? YES NO

If yes, please list: _____

Do you have any allergies or have you ever reacted adversely to medication? (e.g. metals, latex, antibiotics, freezing) YES NO

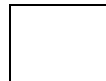
If yes, please list: _____

Do you bleed excessively from a cut or injury or bruise easily? YES NO

Do you or have you used any form of tobacco? YES NO

Are you alcohol/drug dependent? YES NO

WOMEN ONLY: Are you pregnant or suspect you may be? YES NO Due date _____



Have you ever had or been treated/tested for any of the following? Please Check Applicable Conditions:

DA

| | | |
|-------------------------------|-----------------------------|-------------------------|
| A.I.D.S./H.I.V. positive | Gallbladder disease | Liver disease/Jaundice |
| Anemia | Glandular disorders | Lung disease |
| Angina pectoris | Glaucoma | Malignant hyperthermia |
| Arthritis/rheumatism | Head/Neck/Facial injuries | Mental/Nervous disorder |
| Artificial joints (hip, knee) | Heart disease or attack | Mitral valve prolapse |
| Artificial heart valve | Heart murmur | Organ transplant |
| Asthma | Heart pacemaker | Obstructive sleep apnea |
| Blood disorders | Heart rhythm disorder | Psychiatric treatment |
| Cancer | Heart surgery | Rheumatic/Scarlet fever |
| Chemotherapy/Radiation | Hepatitis A, B, C | Sickle cell disease |
| Circulation problems | Herpes | Sinus problems |
| Congenital heart lesions | High/Low blood pressure | Snoring |
| Diabetes | Hodgkin's disease | Stroke |
| Emphysema | Hyper (Hypo) Glycemia | Thyroid Disease |
| Epilepsy or seizures | Intestinal/Stomach problems | Tuberculosis |
| Fainting or dizzy spells | Kidney disease | Ulcers |

DENTAL HISTORY

Previous Dentist: _____ Province or Town: _____

List any dental problem you want treated immediately: _____

Date of last dental visit: _____ Procedure done: _____ X-rays done? YES NO

Have you ever had any of the following? Please Check Applicable Treatment:

| | | |
|---------------------------|----------------------|-----------------------|
| Periodontal (gum) surgery | Root canal treatment | Orthodontics (braces) |
| Crowns and/or Bridges | Dentures | Bleaching of teeth |
| Oral surgery: Broken jaw | Wisdom teeth removed | Implants |

Do you or have you ever experienced any of the following? Please Check Applicable Symptoms:

| | | |
|----------------------------------------------------|--------------------------------------------------------|----------------------------------------|
| Sensitive teeth to heat, cold, sweets and pressure | Popping/Clicking/Pain in jaw joints, ears/side of face | Difficulty in opening or closing mouth |
| Bad breath | Pain/difficulty while chewing | Growths/Sores in mouth |
| Clenching/Grinding teeth | Food catching between teeth | Biting your cheeks or lips |

Concerns about dental treatment: _____ Unhappy with teeth appearance? YES NO

General Release

I've provided an accurate and complete personal/medical/dental history, not omitted any information and had the opportunity to discuss this history. Any change in my health status, I will advise this dental office. I authorize the dentist to perform diagnostic/dental/oral surgery procedures necessary or advisable, including the use of local anaesthetic as indicated. I consent to the collection/use/disclosure/retention of my personal information, and to the release of information needed from/to another health care provider. I understand that responsibility for payment of the dental services for my dependents and me is mine.

Service charges are added to accounts owing over 90 days and then sent to a third-party agency for collections.

I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically.

Patient, Parent or Guardian Signature

Date

Reviewed by treating dentist

Date

\$75 charge for missed and/or appointment changes, without 2 business days' notice.