WELCOME TO OUR DENTAL OFFICE

Receptionist

Name: _____ Birth Date: *dd / mm / yy* 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: *dd / mm / yy*

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_____

DA

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

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.