DENTAL INTAKE FORM

PATIENT INFORMATION

Name Lilla Horvath	**Date of birth** 2021-02-09
Address 1234 Main Street New Westminster, British Columbia VVV777 Canada	**Phone** 555-555-5555 **Email** lillahorvath@hotmail.com
Who may we thank for referring you?	Jordan Smith
Family physician name Bernard Klein	**Phone** 555-555-5555
Emergency contact name Jenny McDonald	**Phone** 555-555-5555

MEDICAL HISTORY

Are you currently seeing a physician for treatment of a recent or ongoing medical condition? Yes

Recent or ongoing medical condition information
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Have you had a serious illness or operation within the last year? Yes

Serious illness or operation information
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Have you ever had an allergic reaction to a drug? Yes

Allergic reactions to drugs information
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Do you smoke? Yes

How much do you smoke? 2 packs/day

List any current medications

Name of drug	Dosage	Frequency
Tylenol	10mg	1/day
Advil	20mg	1/day
Aspirin	15mg	1/day

Check the medical conditions that apply to you

- [ ] Presently in good health
- [X] Chest pain
- [ ] Prolonged Bleeding
- [ ] Allergies
- [ ] Arthritis
- [ ] Asthma/hayfever
- [ ] Heart Murmur
- [X] Heart surgery
- [ ] COPD
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Gastrointestinal disorders
- [X] Nervous Disorders
- [ ] High Blood Pressure
- [ ] Tumor or Cancer
- [ ] Tuberculosis
- [X] Other
- [ ] Artificial joints or stents
- [ ] Cuts in your skin stay open a long time
- [ ] Abnormal bleeding/hemophilia
- [ ] Anemia
- [ ] Bone disorders
- [X] Congenital heart defect
- [ ] Heart Attack
- [ ] Pacemaker
- [X] Diabetes
- [ ] Stroke
- [ ] Hepatitis/Liver problems
- [ ] Herpes (cold sores)
- [ ] Pneumonia
- [ ] Radiation/Chemotherapy
- [ ] Rheumatic Fever
- [ ] Taken medication to strengthen your bones

Other medical conditions
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Gender at birth Female

Please check the following that apply to you

- [X] Taking Oral Contraceptives
- [X] Pregnant
- [X] Nursing

DENTAL HISTORY

Check the dental conditions that apply to you

- [ ] You are a mouth breather
- [X] Your teeth or jaw feels uncomfortable when you awake in the morning
- [X] You are aware of your jaw clicking or popping
- [ ] You have been told that you grind your teeth
- [ ] You have "tension" headaches
- [ ] You are under an abnormally high amount of stress
- [X] You sleep well
- [ ] You have sleep apnea
- [ ] You have been advised to take antibiotics prior to a dental appointment
- [X] Other

Other dental conditions
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Have you ever had orthodontic or invisalign treatment?	Yes
Are you happy with the appearance of your teeth?	No

If no, what would you change?
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The name of your previous dentist or dental clinic	Awesome Dental Clinic
Would you like us to contact them to have your most recent x-rays forwarded to our clinic?	Yes

OFFICE POLICIES

We make every effort to provide you with the finest care and the most convenient financial option. To accomplish this, we work hand-in-hand with you to maximize your insurance reimbursement for covered procedures. We currently follow the current ADA&C Fee Guide for General Dentists. Dental insurance is a contract between you and your insurance. Ultimately it is your responsibility to know your coverage frequencies and annual maximum.

As a courtesy to our patients, we accept the assignment of benefits and will direct bill your insurance.

We ask that you bring all necessary and current insurance information to your initial dental appointment. Should there be any changes with your dental insurance plan in future appointments, we ask that you update your insurance with our staff prior to your visit. Please note: most dental insurance plans do not release specific benefit information to the dental clinic due to the privacy act. However, the patient will always have access to this information online or by calling their benefits provider. If you have any problems or questions, please ask our staff and we will always do our best to help.

We direct bill your insurance and accept the payment directly from your insurance company. You are then responsible for any amount not covered by your insurance company. This may include insurance deductibles, co-pays or if a service provided is not allowed by your plan. **If you provide us with a plan that is not active, you will be responsible for the full cost of treatment provided.**

We accept cash, debit, Visa & MasterCard.

If you prefer contactless payment, please list your credit card number below. We will process the amount not covered by your insurance after your visit and email you a receipt.

Credit Card Number	Expiry	Name of Cardholder
123 456 789 789	02/25	Lilla Horvath

CANCELLATION POLICY

The clinic requires a minimum of 48 hours business notice if an appointment is canceled to avoid a charge. We understand sometimes there are urgent needs that cause a last-minute cancellation, so please provide us with as much notice as possible so we may accommodate other patients who are waiting for an appointment.

Please be mindful of when your appointment is and arrive on time so we may be courteous to all patients and avoid long wait times. We send courtesy appointment reminders, but it is the patients' responsibility to arrive at their scheduled time.

PERSONAL INFORMATION PROTECTION & ELECTRONIC DOCUMENTS ACT (PIPEDA) CONSENT

Our office staff understands the importance of protecting your personal information and we are committed to collecting, using, and disclosing your personal information responsibly. We will only collect, use, and share the information contained in your dental records, including personal information, photos, x-rays, and clinical information, as is reasonably necessary for the following:

- To communicate with other health care providers, including specialists, general dentists, and doctors as it

pertains to your health care or for lawful identification purposes.
- For research, dental health promotion, education and study between colleagues and with dental patients. Your name will remain confidential.
- To obtain information from your dental plan insurance provider on dental coverage and benefits for the purpose of assisting you with estimates, pre-authorizations for treatment, claims and accepting assignment of payment for claims on your behalf. I hereby assign benefits, payable from claims submitted electronically to the dentist\entity submitting the claim from this clinic. The authorization shall remain in effect until the undersigned revokes the same.

AUTHORIZATION

✔ I, the undersigned, certify that all the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I consent to my Dentist, previous Denturist or Physician being contacted if necessary, as further dental/medical information may be required for my dental care. I, the undersigned, hereby consent to the performing of the preventative dental procedures. I, the undersigned, am aware that the whole amount of treatment is due to be paid by me and understand any direct billing to my insurance plan that comes back unpaid is to be paid promptly by me.

Patient signature