ALLIANCE DENTAL SPECIALISTS
Endodontics | Periodontics | Dental Implants

Welcome to our Office

In order to aid in evaluating your dental health thoroughly and completely, please complete the following examination questionnaire. This will become part of your office record and will be held in strict confidence.

PLEASE PRINT CLEARLY

Today's Date: ____/____/____ (D / M / Y)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Child _____ (FIRST NAME / INITIAL / LAST NAME) Birthdate: ____/____/____ (D / M / Y)

Home Address _____ Apt. ____ City _____ Postal Code _____

Home Tel.: ( ) _____ Cell: ( ) _____ E-mail: _____

Occupation _____ Employer _____ Business Tel.: ( ) _____

Parent/Guardian Info: _____ DOB: ____/____/____ Tel: _____

Emergency contact _____ Tel.:( ) _____

Family Doctor _____ Tel. ( ) _____ Referring Dentist _____

Insurance Information:

Do you have dental insurance? ☐ Yes ☐ No

Primary Policy Holder Name _____ Policy Holder's Birthdate ____/____/____ (D / M / Y)

Insurance Company Name _____ Policy/Group# _____ ID# _____

Secondary Policy Holder Name _____ Policy Holder's Birthdate ____/____/____ (D / M / Y)

Insurance Company Name _____ Policy/Group# _____ ID# _____

HEALTH HISTORY

CIRCLE

Have you ever had an unfavourable reaction following dental treatment? Please discuss this with the doctor. **YES NO**

Have you ever had excessive bleeding requiring special treatment? Please discuss this with the doctor. **YES NO**

Female patients, are you or could you be pregnant or nursing? **YES NO**
If pregnant, which month _____

LIST OF ALLERGIES _____

Do you take BABY ASPIRIN? YES ☐ NO ☐

LIST OF MEDICATIONS AND REASON FOR TAKING (include non-prescription drugs) _____

Check off any of the following which you have or have had:

☐ Heart trouble/Angina	☐ High blood pressure	☐ Stomach ulcer
☐ Heart murmur	☐ Anemia	☐ Kidney disease
☐ Asthma	☐ Rheumatic fever	☐ Fainting spells
☐ Diabetes	☐ Lupus	☐ Sinus trouble
☐ Arthritis	☐ Nervous disorders	☐ Neck injury
☐ Jaundice	☐ Cortisone treatment	☐ Cancer treatment
☐ Stroke	☐ Psychiatric treatment	☐ Sickle cell disease
☐ Hemophilia	☐ Migraine/Headaches	☐ Liver disease
☐ Epilepsy	☐ Emphysema	☐ Thyroid disease
☐ Glaucoma	☐ Herpes	☐ Alcoholism
☐ Hepatitis A	☐ Hepatitis B	☐ Mitral valve prolapsed
☐ Addictions	☐ Venereal disease	☐ Artificial valve, joint/prosthesis
☐ TMJ problems	☐ Congenital heart defect	☐ Blood transfusion
☐ HIV+/Aids	☐ Cardiac pacemaker	☐ Tuberculosis (TB)

Do you have or have you had any other diseases or medical problems not listed on this form? _____

DENTAL HISTORY

Are you presently in pain? **YES NO**

Is any part of your mouth sensitive to the following? **YES NO**

☐ **Hot** ☐ **Cold** ☐ **Biting pressure**

☐ **Sweets** ☐ **Other** _____

Primary complaint _____

I hereby state that the above medical history is to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

_____

Financial Policy. The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but businesslike understanding between doctor and patient. We feel that misunderstanding can be minimized if financial policies are agreed upon at the beginning of treatment. The following statements are made to acquaint you with our policy. If you have any questions regarding insurance, billing or financial policy, feel free to discuss this with our receptionist.

* Accounts that are 60 days overdue will be charged interest.
* Fees quoted at the initial appointment will not increase, however, broken appointments or surgical intervention may constitute an additional fee.
* Our fee does not include the cost of a permanent restoration – to be done by your own dentist after your root canal has been completed.
* All fees are payable upon completion of treatment.

Alliance Dental Specialists
Personal Information Consent Form

We are committed to protecting the privacy of our patient's personal information and to utilizing all personal information in a responsible and professional matter. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patient's such as names, addresses, work addresses, home telephone numbers, work telephone numbers and e-mail address. (Collectively referred to as "Contact Information"). Contact information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies
- To contact patients concerning the need for further dental treatment if needed
- To send patients informational material about our dental practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services. We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient's Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians, if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

Dentists are regulated by the Royal College of Dental Surgeons of Ontario, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

☐ I consent to the collection, use and disclosure of my personal information as set out above.

SUBMIT CLEAR FORM