**NEW PATIENT FORM** *(all information is strictly confidential and will remain in the office)*

|  |  |
| --- | --- |
| First Name: Last Name: Preferred Name: Address: City: Postal Code: Date of Birth: Age: Sex: Marital Status: Occupation: Employer:  | Email: Cell Phone: Home Phone: Work Phone: Preferred Contact Method: (circle)  EMAIL / PHONE / TEXTIf phone or text, which number? (circle) CELL / HOME / WORKHow did you hear about our office?  |

**If the patient is under 18 years of age**

Parent/Guardian name: Phone:

Parent/Guardian name: Phone:

Who is financially responsible for this account if the patient is under 18 years old?

**Emergency Contact**

Name:

Relationship:

Home Phone: Mobile: Work Phone:

**Medical Information**

Medical Doctor:

Phone:

Date of last physical exam:

Do you consider yourself to be in good health?

Are you presently under the care of a medical doctor? If yes, please specify:

Please list any medication you currently take, including non-prescription, herbal supplements, and/or vitamins:

Please list any allergies or if you have had any reactions (to medications, anaesthetics, metals, latex, antibiotics, pain killers, dairy etc.):

Do you have to take any antibiotics? If yes, why?

Have you had heart surgery? If yes, please specify:

Do you have any artificial prosthesis (joints, heart valve, etc.)? If yes, please specify:

Do you have abnormal bleeding? Do you become breathless easily?

Do you smoke? If yes, how much? Do you take recreational drugs?

Are you taking birth control pills? Are you pregnant?

|  |
| --- |
| Do you have any of the following? Please tick all that apply: |
|  Heart Murmur Heart Trouble Chest Pain Blood Disorders High Blood Pressure Low Blood Pressure Anemia Stroke Arthritis |  Sinus Problems Headaches Ulcer Herpes Venereal Disease Hepatitis Type?  HIV/AIDs Tested?  Thyroid Problems Diabetes |  Liver Disease Kidney Trouble Asthma Tuberculosis Emphysema Rheumatic Fever Digestive Disorders Glaucoma Head/Neck Injuries |  Nervous Problems Epilepsy Psychiatric Care Antidepressants Alcohol/Drug Dependency Cancer Chemotherapy Radiation Therapy Other:  |

**Dental History**

Are you having any discomfort at this time? If yes, please specify:

Have you had regular care from a dentist?

Name of previous Dental office?

When was your last dental visit?

Phone Number:

Is there often bleeding when you floss?

Have you ever been given local anesthetic?

Are you aware of any lump or swelling in your mouth?

Are you satisfied with the appearance of your teeth?

Are you tense during dental visits?

**Insurance Information**

**Primary Insurance Company**:

Name of Policy Holder:

Date of Birth:

Policy #

ID #

Employer:

**Secondary Insurance Company**:

Name of Policy Holder:

Date of Birth:

Policy #

ID #

Employer:

Consent to Treat and Financial Policies

Thank you for choosing Heavenly Dental as your dental provider. We are committed to providing you and your family the best care possible.

**Consent to Treat:**
By signing, you consent to treatment in our office. This includes any examinations, tests, x-rays or other procedures which may be deemed advisable or necessary.

You will be notified of any such testing and you have the right to an explanation of any procedures and their risks, benefits, alternatives, and charges before they occur. Your signature here consents to these procedures.

*It is your responsibility to inquire about and/or decline any such procedures.* The occurrence of a procedure indicates that you understand the risks and benefits and have received a satisfactory response to your questions, if any.

**Insurance:**
If the patient is covered by an insurance plan that allows assignment of benefits, we will file your insurance claim for you. By signing below, you

* allow us to file this claim for you and assign all insurance benefits arising from the claim to be paid directly to our office.
* accept responsibility for any charges not covered by your insurance plan and which are legally billable to the insured; you accept full responsibility if your insurance is terminated or otherwise invalid.

If the patient is covered by a plan where benefits cannot be assigned we will provide you with the necessary documentation to file your own claim for reimbursement. In this case you are expected to pay the full balance at the time of treatment.

If we are unable to collect from your insurance company after 90 days we will collect the remaining balance from you and provide you with the paperwork necessary to submit on your own.

**You will be financially responsible for ANY non-covered services**

**Policy on Missed Appointments**:
Please give us two business days notice to reschedule an appointment. **If an appointment is cancelled within 24 hours of the appointment time, it will count as a missed appointment.** Missed appointments will incur a charge of **$25 per ½ hour of appointment time missed**. If you are 15 MIN LATE your treatment may be cancelled at our discretion, and it will be counted as a MISSED APPOINTMENT. This balance must be paid before any further appointments can be scheduled. If you need further information on this policy, please call the office.

I acknowledge that I have read and agree to the Consent to treatment, Insurance Assignment (if applicable) and Policy on Missed Appointments as written above.

Patient Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent/Guardian Name :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (DD/MM/YYYY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_