



# WELCOME TO OUR DENTAL OFFICE



Receptionist

Name: \_\_\_\_\_ Birth Date:  Gender: \_\_\_\_\_

(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.** Note: Debit cards may not be utilized, only credit cards. 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? (eg: metals, latex, antibiotics, freezing) YES NO

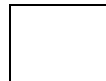
If yes, please list: \_\_\_\_\_

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 and that **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.***