



PATIENT INFORMATION (ADULT)

Patient ID # _____

Prefix	Last Name	First Name	Middle Initial	Preferred Name
Street Address		Apt. /R.R.	City / Town	Province
Postal Code				
Home Phone:	Mobile:	Work #	Ext. #.	Email:
Birthdate (dd/mm/yy)	Age	Sex	Marital Status	Health Card #
Employer	Occupation	Business Address		Best time for appointments
Emergency Contact	Relation	Contact #	Contact Email	

Prefix	Partner/Spouse Last Name	First Name	Middle Initial	Preferred Name
Address as above: <input type="checkbox"/> OR Street Address		Apt. /R.R.	City / Town	Province
Postal Code				
Home Phone:	Mobile:	Work #	Ext. #.	Email:
Birthdate (dd/mm/yy)	Employer	Occupation	Business Address	
How did you become aware of Santé Dental? (Circle any that apply) Friend/Family Website Building/Sign Google/Internet Search Other Web-based Rating Site: _____				Who may we thank for the referral? _____

BENEFIT INFORMATION: (circle)	Employer	Private	Military	Veteran	ODSP	NIHB	ON Works
Benefits belong to: Self <input type="checkbox"/> Spouse <input type="checkbox"/>	<u>Primary</u> Insurance:	Group/Contract #		Certificate/ID #	Division #		
Benefits belong to: Self <input type="checkbox"/> Spouse <input type="checkbox"/>	<u>Secondary</u> Insurance:	Group/Contract #		Certificate/ID #	Division #		
EDI	I authorize release, to my benefit company, plan administrator, plan member, the information contained in claims submitted.						Signature _____

OFFICE POLICIES & PROTOCOLS	
<p>COMMUNICATION: All information gathered is necessary for Santé Dental to provide you with the best in dental care and is considered confidential. By providing us with phone numbers and email, you are giving consent for us to contact you using your preferred method(s).</p>	Patient Initials _____
<p>APPOINTMENT TIMES: Your appointments are times set aside specifically for you, which our dental care team prepares for in advance. The appointments, once scheduled are considered confirmed. Santé Dental makes every attempt to contact you in advance as a reminder. If you are unable to keep your appointment, the courtesy of 2 full business days notice is expected. Failure to extend Santé Dental this courtesy could result in a missed appointment fee.</p>	Patient Initials _____
<p>ACCOUNTS / PAYMENTS: Please indicate with your initials your understanding of Santé Dental's payment policy: I will pay in full, per visit, at the conclusion of my appointment by one of the approved payment methods — Visa, Mastercard, American Express, Interac/debit or cash. My Santé Dental Patient Care Coordinator will submit on my behalf, any claim forms required by my primary benefit plan provider to facilitate reimbursement for the amounts detailed in my plan. I will be provided any further claim forms needed for secondary benefit plans for which I may be eligible, for my submission. I am aware that while my Santé Dental Patient Care Coordinator will assist, it is my responsibility to understand the details of various conditions and limits that may apply to my plan(s).</p>	Patient Initials _____
<p>I am aware that my dental care providers are NOT responsible for any portion of the fees not covered or paid for by the benefit plan carrier. The role of my dental health team is limited to the provision of dental care and this is separate from any aspect of my benefit plan. Thus, I understand that I am financially responsible for all dental health care services which I have received.</p>	Patient Initials _____



MEDICAL HISTORY / CONDITION INFORMATION

Patient's Full Name: _____
 Date of Birth: _____ Today's Date: _____

Physician's Name _____ Phone # _____ Last Visit: _____

Are you currently under any treatment by your physician? YES NO
 If 'YES', what for? _____

Other Health Care Providers:
 Name: _____ Phone # _____ What for: _____
 Name: _____ Phone # _____ What for: _____

Pharmacy:
 Are you taking any prescription or non-prescription medications? YES NO
 Current list, amount and usage of medications:

Do you have any allergies or sensitivities to any medications? _____

MEDICAL CONDITIONS: Do you have, or have you had any of the following? (NS = not sure)								
	YES	NO	NS		YES	NO	NS	
Serious Illness				Liver / Kidney Problems				
Any Surgeries				Hepatitis: A B C				
Heart Failure / Attack				Diabetes				
High / Low Blood Pressure				Stomach / Intestinal Problems				
Heart Murmur				Thyroid Disease				
Heart Surgery				Bleeding Disorders				
Chest Pains / Angina				Joint Replacement Surgery				
Heart Pacemaker				Arthritis / Rheumatism				
Stroke / TIA				Circulation Concerns				
Fainting or Dizzy Spells				Mental / Nervous Disorders				
Rheumatic / Scarlet Fever				Cancer				
TB (Tuberculosis)				Chemotherapy / Radiation				
Epilepsy or Seisures				Psychiatric Care				
Immuno-compromising Disease				Drug or Alcohol Dependency				
Lung / Breathing Problems				Head / Neck Injury				
Emphysema				Pain in Jaw Joints				
Asthma				Any type of Accident				

Additional comments about medical conditions you think we should know about:

B/P Reading: _____

For Women: Are you... Pregnant: Y N Nursing: Y N taking Birth Control Pills: Y N on a Fertility Program: Y N

I certify that I have read, understood and accurately completed the Patient Information & Medical Histroy / Conditions questionnaire to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me and I have had the chance to ask questions and receive answers regarding any medical/dental histories. I consent to my current and previous dentists and/or physicians and all other health care providers being contacted regarding my current and past conditions. I authorize the dentist to perform necessary diagnostic procedures and treatments as required to achieve the proper level of dental care.

Date: _____, 20 ____ Signature: x _____

Reviewed by: _____ / _____ on _____