santé dental

DEPENDANT PATIENT INFORMATION

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	Health Card #

School/Employer	Grade / Position	Best time for appointments

Emergency Contact	Relation	Contact #	Contact Email

Prefix	Parent/Guardian Last Name	First Name	Middle Initial	Preferred Name

Address as above: ☐ 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:	Primary Insurance:	Group/Contract #	Certificate/ID #	Division #
Benefits belong to:	Secondary 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 (for Parent/Guardian)

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).

Patient Initials _____

APPOINTMENT TIMES: Appointments are times set aside specifically for your dependant, which our dental care team prepares for in advance. The appointments, once scheduled are considered confirmed. Santé Dental makes every attempt to contact the patient in advance as a reminder. If the appointment is unable to be kept, the courtesy of 2 full business days notice is expected. Failure to extend Santé Dental this courtesy could result in a missed appointment fee.

Patient Initials _____

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 the 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).

Patient Initials _____

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.

Patient Initials _____

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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 Dependancy			
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 _____