HEALTH HISTORY QUESTIONNAIRE

All the information that you provide in this questionnaire is strictly confidential and will become part of your dental record.

PATIENT INFORMATION	
Name (First name, Middle Initial, Las name):	☐ **Male** ☐ **Female**
Marital Status: ☐ **Single** ☐ **Married** ☐ **Other**	**Date of Birth: (dd/mm/yyyy)**
Address:	**City, Postal Code:**
Email address:	**Home phone #:** **Cell phone #:**
How did you find out about our office: ☐ Previous patient ☐ Neighborhood ☐ Yellow pages ☐ Community newsletter ☐ Referral from existing patient (if so, please provide the patient's name so we can thank them for the referral), ☐ Other	

MEDICAL HEALTH HISTORY		
1. Are you in good health now? If no, please explain:		☐ Yes ☐ No
2. Are you taking any medication, pills or drugs? If yes, please specify:		☐ Yes ☐ No
3. Are you under the regular care of a physician, besides regular check ups? If yes, please explain:		☐ Yes ☐ No
4. Have you had any abnormal bleeding after a cut, bruise, surgery or previous tooth extraction?		☐ Yes ☐ No
5. **Allergies** – Are you allergic or have had an abnormal reaction to the following:		
☐ Penicillin	☐ Codeine	☐ Sulpha drugs
☐ Asprin (ASA)	☐ Latex	☐ Local anesthetic (freezing)
6. Do you have any allergies not listed above? If yes, please explain:		☐ Yes ☐ No
7. Have you ever had any radiation therapy?		☐ Yes ☐ No
8. Have you had any joint replacements? When?		☐ Yes ☐ No
9. Have you ever needed antibiotics premedication before dental cleanings?		☐ Yes ☐ No
10. Women: Are you pregnant? If yes, when is your due date?		☐ Yes ☐ No
11. Is there anything else we should know about your health?		☐ Yes ☐ No

DENTAL HISTORY

1. What dental conditions or concerns do you have with your teeth?	
2. What would you like to have done with your teeth?	
3. Are you having discomfort at this time? If yes, please explain:	□ Yes □ No
4. When was your last dental exam and cleaning?	
5. Were x-rays taken at that time?	□ Yes □ No
6. Do you have any of the following: □ Bleeding gums □ Swollen gums □ Pain in the gums □ Receding gums □ Loose teeth □ Drifting teeth	
7. Do you have any lumps, swellings, sores or lesions in your mouth?	□ Yes □ No
8. Do you have any clicking noise in your jaw joint?	□ Yes □ No
9. Do you ever get lock jaw (open or closed)?	□ Yes □ No
10. Do you have any jaw pain or headaches?	□ Yes □ No
11. Do you clench or grind your teeth?	□ Yes □ No
12. Do you have any missing teeth that need to be replaced?	□ Yes □ No
13. Are you satisfied with the appearance of your teeth?	□ Yes □ No
If no, please explain what you would like to be done?i	
14. How often do you: Floss ____________ times per day. Brush____________ times per day.	
15. Have you had any complications with past dental appointments?	□ Yes □ No
If yes, please explain:	
16. Are you anxious/tense about dental visits?	□ Yes □ No

17. Do you have any of the following:

□ Sensitive teeth	□ Spaced or crooked teeth	□ Dry mouth	□ Gagging
□ Difficulty chewing	□ Unsatisfactory dentures	□ Bad breath	□ Other

If you selected Other, please specify:

CONSENT FOR TREATMENT

I hereby certify that the Medical and Dental Histories are accurate and complete to the best of my knowledge. I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of sedatives, local anesthetic, or any other drugs as indicated. I have understood everything and I will assume responsibilities for fees associated with those procedures.

Date:______________________ Patient's (Parent's) Signature______________________________

Cancellation Policy

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we try to do our very best. We have flexible hours and are open evenings and Saturdays to meet a variety of schedules. We also work hard to stay on schedule to minimize your waiting time in our office.

A scheduled appointment is a commitment between the patient and the doctor or hygienist. We have reserved that time **just for you**. When appointments are missed or cancelled at the last minute, that time is lost. We ask that when you schedule your treatment, you make every effort to keep that commitment.

It is your responsibility to keep track of your appointments. As a courtesy, we send you hygiene reminder cards 1 month prior to a booked appointment and make confirmation calls 2-3 days prior to your appointment. Please ensure that we have a current phone number on file so we can remind you of your appointments.

However, if you find that you cannot keep your scheduled appointment, a minimum of **2 business days (48 hours notice)** will be required for cancellations or changes of the appointment time. If insufficient notice is given or you do not show for your appointment, a **$50.00 fee** will be charged to your account/credit card on file.

If you have any questions regarding this or any of our policies or procedures, please do not hesitate to contact us.

Thank you for your understanding and co-operation.

Image DENTAL

I have read and understood the above appointment cancellation policy.

Patient (Parent) Signature

Dental Insurance Processing

Due to the Canadian Privacy Act that came into effect January 2004 we are unable to access ***any*** information from your insurance company regarding your dental plan. Dental insurance is a contract between an individual, the employer, and the insurance company. This insurance is based on the coverage that has been contracted, not on your dental care needs. It is **your responsibility** to know the details of your insurance coverage, including annual maximums, frequencies, and other limitations. If you have your insurance handbook, please bring it to the office and we can help you understand your insurance plan and put your information into your chart.

- Our office has two ways of handling payments from patients with dental insurance coverage (please select): You pay the bill at the time of service and we will submit the dental services **paid by you** to your insurance company in which you will receive payment from your insurance company. Payment can be made to our office by Visa, MasterCard, debit or cash. This option allows you to receive the benefit program your credit card offers you.

- We accept **direct payment** from your insurance company for payment of the dental procedures performed and any outstanding balances are paid by you.

If we are collecting payment from your insurance company (option 2 selected above), we require that you leave a **valid credit card number** on file. This allows us to apply any outstanding balance not covered by your dental insurance plan(s). We will mail you a statement of the charges put through to your credit card and please call us if you have any questions or concerns.

Please provide your insurance information for processing:

First Insurance Plan	Second Insurance Plan
Insurance company:	**Insurance company:**
Name of employer insurance plan is with:	**Name of employer insurance plan is with:**
Name of insurance plan owner:	**Name of insurance plan owner:**
Date of Birth of the insurance plan owner: (dd/mm/yyyy)	**Date of Birth of the insurance plan owner: (dd/mm/yyyy)**
Group plan #:	**Group plan #:**
Individual plan #:	**Individual plan #:**
What is the insurance plan benefit year (Jan-Dec)?	**What is the insurance plan benefit year (Jan-Dec)?**

Please present the dental insurance card(s) to front reception to set up in your patient record in our system to process dental charges to your insurance company.

I have read and agree to the above office policy. I understand that I am fully responsible for the fees of the services rendered, regardless of any insurance I may have:

Signature: ______________________

Date: ______________________

Credit Card Authorization Form

I, ____ authorize Image DENTAL to apply any outstanding balance on my account not covered by my dental insurance plan(s) to the credit card listed below.

Please list any dependents and spouse that will be covered under the listed credit card number:

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I understand that Image DENTAL will send a copy of the credit card receipt to my current address on file.

Type of credit card; **(Visa or MasterCard only)**	
Credit card #:	
Expiry date:	
Name on credit card:	
Signature of cardholder:	
Today's date:	