PATIENT REGISTRATION

Please complete the following personal information:

Mr. Mrs. Ms. Miss.		
Name:		Middle initial:
Address:	City:	
Province:	Postal Code:	
Home phone:	Cell phone:	
Work phone:	Best place to contact you? Home Cell Work	
Date of Birth:	E-Mail:	
Parent (Guardian) if child: or spouse name :		Gender: Male Female

Emergency Contact:

Name:
Relationship to patient:
Phone number:

Getting to know you:

Employer:	
Occupation:	
Medical Doctor:	Phone number:
How did you hear about our office?	

Dental Insurance Info:

Insurance Company:		
Policy Holder Name:	Birthdate:	Employer:
Policy number:	ID Number:	A)Basic% ______ B)Major%______ C) Ortho%______ deductible_____ Annual max:_________

Dental Insurance Info:

Insurance Company:		
Policy Holder Name:	Birthdate:	Employer:
Policy number:	ID Number:	A)Basic% ______ B)Major%______ C) Ortho%______ deductible_____ Annual max:_________

HEALTH HISTORY

CIRCLE

1. Are you feeling pain or discomfort at this time? .... YES NO
2. Have you had a medical examination in the last year? .... YES NO
3. Do you feel very anxious about having dental treatment? .... YES NO
4. Have you been a patient in the hospital during the past two years? .... YES NO
5. Please state your physician's Name________________________ Phone #________________________
6. If you are using any medication now, please list ____
7. Are you allergic or have you reacted adversely to any of the following? - PLEASE CIRCLE -

Aspirin	Nitrous Oxide	Valium	Local Anesthetic	Latex
Darvon	Erythromycin	Scopolamine	Novocain	
Codeine	Tetracyline	Penicillin	Sleeping Pills	
Demerol	Percodan	Other Antibiotics	Nembutal/Seconal	

8. Are you aware of being allergic to any other medications or substance? .... YES NO
9. Circle any of the following which you have had or have at present:

Allergies of Hives	Drug Addiction	Heart Disease or Attack	Persistent Cough
Anemia	Rheumatism	Fainting or Dizzy Spells	Angina Pectoris
Blood Transfusion	Scarlet Fever	Diabetes	Hemophilia
Bruise Easily	Chemotherapy	Any lung disease	Congenital Heart Lesions
Fever Blisters	High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice	Heart Pacemaker
Hepatitis A (infectious)	Heart Failure	Emphysema	A.I.D.S.
Kidney Trouble	Glaucoma	Ulcers	Pain in Jaw Joints
Sickle Cell Disease	Cosmetic Surgery	Rheumatic Fever	Sinus Trouble
Stroke	Cortisone Medicine	Nervousness	H.I.V. +
Tuberculosis (TB)	Hepatitis B (serum)	Artificial Heart Valve	Thyroid Disease
Stomach Problems	Artificial Joints(Hip/Knee)	Arthritis	Epilepsy or Seizures
X-Ray or Cobalt Treatment	Cold Sores	Heart Surgery	Cancer

10. Do you wish to speak privately to the Doctor about any medical condition? .... YES NO
11. When walking up stairs or taking a walk, do you ever stop because of pain your chest? .... YES NO
12. Do your ankles swell during the day? .... YES NO
13. Have you lost or gained more than 10 pounds in the past year? .... YES NO
14. Do you ever wake up from sleep short of breath? .... YES NO
15. Are you on a special diet? .... YES NO
16. Is there anything you would like to change about your smile? .... YES NO
17. Do you have a tendency to faint? .... YES NO
18. Do you have frequent severe headaches? .... YES NO
19. Have you had a regular dental examination (annually) in the past? .... YES NO
20. Do you have any disease, condition, or problem not listed? .... YES NO

FOR WOMEN ONLY Are you pregnant? YES NO If yes, what month?________________________

CONSENT

The undersigned hereby authorizes Doctor, upon consultation and direct consent from patient to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) ________________________ further to my consultation and direct consent. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements including insurance or otherwise, have been made.

Patient Signature________________________ Date ________________________

Medical Alert

WELCOME TO BAYVIEW DENTAL & IMPLANT CENTRE
New Patient Agreement

I, ______________________________, understand that:

The financial policy of this clinic is to pay at the time that services are rendered.

I am responsible for all the fees incurred for my own treatment and/or for the treatment of a minor/dependant that I am responsible for, **regardless of insurance coverage**.

That as treatment progresses, fees may have to be adjusted, but I will be informed of these adjustments.

BayView Dental & Implant Centre requests **2 business days' notice for all cancellations** and that without such notice there will be a fee of $50 placed in my account, which is to be paid before my next appointment can be made.

Treatment that is required is not always the same as treatment that is covered by my insurance plan. All treatment being suggested by the dental health practitioners at BayView Dental is being done so with my dental health in mind.

I am expected to be on time for all my appointments and should expect the same from the dental health practitioners at BayView Dental. However, I am also aware that sometimes unforeseen emergencies do come up and may interrupt the regular schedule of appointments.

I am responsible for my insurance coverage. This includes giving the dental office the correct and current information related to my plan in order to submit claims accurately.

BayView Dental & Implant Centre is not aware of my dental coverage details unless I have provided it to them. Any inquiries about my insurance plan need to be directly directed by me.

* If there are any further questions about our policy, please ask our receptionists prior to signing this form.

______________________________________ __________________

Responsible Party Signature Date Signed