Medical History

Please complete the following personal information: Office ID#

Mr. Mrs. Ms. Miss.		
First Name:	Last Name:	Middle Initial:
Address:	City:	
Province:	Postal Code:	
Home Phone:	Mobile Phone:	
Work Phone:	Best place to contact you? Home Cell Work	
Date of Birth:	Email:	
Parent (Guardian) if child or Spouse name:		

Emergency Contact:

Name:
Relationship to patient:
Phone Number:

Getting to know you:

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

Dental Insurance Information:

Insurance Company:		
Policy Holder Name:	Birthday:	Employer:
Policy Number:	ID Number:	Breakdown: A)Basic% _____ B)Major% _____ C)Ortho% _____ Deductable% _____ Annual Max% _____

Secondary Insurance Company:

Policy Holder Name:	Birthday:	Employer:
Policy Number:	ID Number:	Breakdown: A)Basic% _____ B)Major% _____ C)Ortho% _____ Deductable% _____ Annual Max% _____

Medical History

1. Are you currently being treated for any illness? Yes ____ No ____ If yes, please provide details: ______________________________

2. When was the last time you had a medical examination? ______________________________
3. Have you been hospitalized in the last 2 years? Yes ______ No______
4. Have you ever been advised to take antibiotic pre-medication prior to dental treatment? Yes __ No __

5. Are you allergic or have you reacted adversely to any of the following?

Aspirin	Nitrous oxide	Valium	Local anesthetic
Darvon	Erythromycin	Scopolamine	Novocain
Codeine	Tetracycline	Penicillin	Sleeping pills
Demerol	Percodan	Nembutal/Seconal	Latex

Other allergies ______________________________

6. Are you presently taking any kind of medication? If yes, please specify:

Drug ______________________________ Reason ______________________________
Drug ______________________________ Reason ______________________________
Drug ______________________________ Reason ______________________________
Drug ______________________________ Reason ______________________________

7. Please indicate below (√) if you presently have or have ever had any of the following:

AIDS/HIV	Eating disorders	Mental or nervous disorder
Alcohol or drug dependency	Epilepsy/seizures	Rheumatic fever
Arthritis	Fainting /dizzy spells	Stomach ulcers
Artificial joints or valves	Heart disease	Stroke
Asthma	High / low blood pressure	Thyroid disease
Blood transfusion	Hyper/hypo glycemia	Tuberculosis
Cancer/radiotherapy/chemotherapy	Kidney disease	Venereal/communicable disease
Cold sores	Liver Disease	
Diabetes	Lung Disease	

8. Do you smoke? If yes, how much per day? _______ per week? __________

9. Female patients – Are you pregnant? Yes ___ No ___ Breastfeeding? Yes ___No ___
10. Do you grind or clench your teeth? Yes ___ No ___
11. Do you suffer from headaches____ earaches_____ or neck aches_____?
12. Do you have anxiety regarding dental treatment? Yes ___ No ___

13. Is there any additional information related to your health that has not been addressed above?

____

____

Consent Payment & Treatment

I hereby certify that the Medical and Dental History is 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 local aesthetic or any drugs as indicated. I will assume responsibility for fees associated with any procedures. Payment is due the date of service. I understand that a possibility of complications exists for each treatment.

______________________________ ______________________________

Patient Signature (or guardian) Date

Welcome to Bayview Dental and Implant Center
New Patient Financial Agreement

I, ____ understand that:

- The financial policy of this clinic is that all fees are due and payable when services are rendered.
- As a courtesy to the patients, Bayview Dental and Implant Center is willing to accept assignment directly from most dental insurance companies.
- I am to inform Bayview Dental of what my benefits are and if there are any changes to them, prior to my appointment.
- I am responsible for any portion of payment for services I have agreed to and have been performed, that is not paid by my dental benefits plan.
- Any conflict between the accepted assignment of benefits and the expected amount to be received from my dental plan is between me and my insurance company.
- As treatment progresses, fees may have to be adjusted, but I will be informed of these adjustments.
- Treatments that are required are not always the same as treatment that is "covered" by my insurance plan. All treatment being recommended by the dental health practitioners here at Bayview Dental and Implant Center is being done so with my dental health in mind.
- This clinic requires 2 business days' notice for all cancellations or changes to my appointment and that without such notice, my account may be subject to a rebooking fee.
- I am expected to be on time for all my appointments and should expect the same from this clinic. However, I am aware that sometimes unforeseen circumstances, such as emergencies or sudden change in treatment needs, may interrupt the regular scheduled appointments.
- **I agree that Bayview Dental and Implant Center may contact my insurance company on my behalf to review my coverage limitations, maximums, treatment pre-determinations, claim status and payments.**

______________________________ ______________________

Signature *Date*