Welcome to Wyndam Manor Dental Care

(Please fill out both sides.)

Confidential Patient Information

Patient Name: ____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other____________

Birth Date: (DAY / MONTH / YEAR)__________________________

Name of Spouse:_________________________________ Names of Children:_______________________

Phone (Home): _______________ ___**(Work):** _______________ Ext:______ Best time to call:____________

Mobile _______________________Email_____________________________

Address: ____
Street Apartment #

____
City Province Postal Code

Health Information

Name of Previous Dentist:___________Date of Last Dental Visit: ____________Reason for this visit:______________

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV
☐ Allergies __________
____
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ **Growths**

☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Migraine Headaches
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:__________

☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoking
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

Please list your Medications:

____
____
____
____
____
____
____

- Have you ever had any complications following dental treatment? ☐ No ☐ Yes, please explain: ________________
- Have been to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes, please explain: _______
- Are you now under the care of a physician? ☐ No ☐ Yes, please explain:_________________________________
- Name of Physician: ____ Phone:_________________________
- Do you have any health problems that need further clarification? :____

Is there anything else you would like to add to help us make your visits more comfortable?

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, ☐ Shopping in Plaza ☐ Road Sign
☐ Google ☐ yellowpages.ca ☐ Yellow Pages Book ☐ Existing Patient ☐ Other: ____________________________

Special Concerns:

Are you nervous about dental treatment? ▯ no ▯ yes ____________________________
Would you like more information on tooth whitening? ▯ no ▯ yes ____________________________
Would you like more information on braces? ▯ no ▯ yes ____________________________
Are you aware of night time tooth grinding? ▯ no ▯ yes ____________________________
Do you require a sports mouth guard? ▯ no ▯ yes ____________________________

We provide our patients with the option to participate in our online patient communication system. Some of the features include the ability to:
Request Appointments Online
Confirm Appointments via Email
Receive Text Message Appointment Reminders
You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email or by replying to a text message with "STOP". Standard Text Messaging rates apply.

Please provide signature if you would like to receive email and/or text messages from Wyndam Manor Dental Care__________________________________.

Insurance Holder's Information

Primary Insurance Plans

Name of Insured: ____ Is insured a patient? ▯ Yes ▯ No
Last First MI

Insured's **Birth Date:** _________________ **ID #:** ______________________ **Group #:**____________________

Insured's Address: (if different from patient's Address)

____
Street City Province Postal Code

Insured's Employer Name: ____

Patient's relationship to insured: ▯ Self ▯ Spouse ▯ Child ▯ Other____________________

Insurance Plan Name:____

Secondary Insurance Plans

Name of Insured: ____ Is insured a patient? ▯ Yes ▯ No
Last First MI

Insured's **Birth Date**: _________________ **ID #:** ______________________ **Group #:**____________________

Insured's Address: (if different from patient's Address)

____
Street City Province Postal Code

Insured's Employer Name: ____

Patient's relationship to insured: ▯ Self ▯ Spouse ▯ Child ▯ Other____________________

Insurance Plan Name:____

Please initial all applicable items:

___ I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.

___ I hereby assign my benefits payable from claims submitted electronically or by mail to the dentists of Wyndam Manor Dental Care and authorize payment directly to him/her.

___ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Financial Policies

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

All estimates for care approximate.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: _____________ Relationship to Patient:_______________
Signature of patient, parent, guardian, or guarantor of payments

____
Printed Name of patient, parent, guardian, or guarantor of payment