

Welcome to Wyndam Manor Dental Care

(Please fill out both sides.)

Confidential Patient Information

Patient Name: _____

Last First MI

Male Female Other _____ Married Single Child Other _____

Birth Date: (DAY / MONTH / YEAR) _____

Name of Spouse/Parent: _____ 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:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS / HIV
<input type="checkbox"/> Allergies _____

<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fainting
<input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy
Due date: _____
<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Smoking
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Penicillin Allergy

<i>Please list your Medications:</i>

_____ |
|---|--|---|---|

• 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

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

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.

Signature of patient, parent, guardian, or guarantor of payments

Date: _____ Relationship to Patient: _____

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

