

Patient Name: _____ DOB: _____ Address: _____
Postal Code: _____

Phone # H: _____ C: _____ Email: _____

Emergency Contact: _____ Phone #: _____

How did you hear about our office? _____

DENTAL Insurance Carrier: _____ Group/ Policy #: _____ ID/ Cert #: _____

Policy holder: _____ DOB: _____

2nd Insurance Carrier: _____ Group/ Policy #: _____ ID/ Cert #: _____

Policy holder: _____ DOB: _____

MEDICAL

****Do you require PREMEDICATION For Dental Appointments, if so, why?** _____

****Woman - Are you pregnant?** _____ **Due Date:** _____ **Contraceptive Name:** _____

List any Medication you are taking (Naturopath/ Prescriptions) _____

Please circle if you are allergic to: Penicillin, Sulfa, ASA, Codeine, Erythromycin, Latex

List and other Allergy if any: _____

What Pharmacy do you use? _____

Medical Treatment Family Dr: _____ **Phone:** _____

Treatment, are you currently under care of a physician or specialist? If yes, please specify: _____

List any past or planned surgery: _____

Please Circle:

If you have or have had: Depression, Diabetes, Kidney Disease, Hepatitis, Asthma, Cancer, Epilepsy, Tuberculosis

If you have or have had: Reactions to Local Anaesthetics, Thyroid Disease, Stroke, Rheumatic Fever

If you have or have had: Osteoporosis, Arthritis, Congenital Heart Lesions,

If you have or have had: Heart Disease, Heart Attack, High Blood Pressure, Heart Murmur, Pacemaker

If you have or have had: Joint Replacements, Communicable Diseases, HIV Positive

Date of Diagnosis or treatment details that apply to above conditions: _____

Name of Previous Dentist: _____ **Phone #:** _____ **Date of last visit:** _____

Main reason for your visit today? _____

How would you change your smile? _____ **Whiter Teeth?** _____

Do you suffer from Dental Anxiety? _____

Have you ever had any injury, surgery or x-ray therapy to the face or jaw? _____

Please Circle if you have or have had any of the following:

Ortho Treatment, Wisdom Teeth Extracted, Date of extractions _____

Loose Teeth, Bleeding Gums, Periodontal Treatment, Food Impaction, Bad Breath, Unpleasant Taste

Swelling in the mouth, Oral Blisters, Cold Sores

Do you smoke? _____ **How Much?** _____

Do you experience Tooth Sensitivity to: Cold _____ Hot _____ Sweets _____ Pressure _____

I consent to photos being taken for the use of treatment planning and patient education. In compliance with Canada's Anti-Spam Legislation, we ask your consent in order to continue communicating with you electronically.

Patient /Guardian Signature: _____ **Date:** _____ **Dentist Signature:** _____



COBBLESTONE
dental care

New Patient Information and Consent

OFFICE CANCELLATION POLICY

If you miss your confirmed dental appointment, it is your responsibility to contact the office to schedule any future appointments. We require 48 BUSINESS HOURS NOTICE for changes to our schedule. This allows us to offer that appointment to another patient who may be in need. Your dental visit is reserved specifically for you, in a time slot that best suits your schedule. We are aware that on occasion situations arise where changes need to be made to the reserved time.

NEW PATIENTS WITH DENTAL INSURANCE PLANS

Payment options AT THE TIME OF YOUR APPOINTMENT are:

Visa, Mastercard, and Debit

Upon providing the office with complete and correct policy information, dental claims are submitted electronically (if permitted under your plan) and received by your Insurance Carrier at the time of your appointment. The Insurance payment is DIRECTED TO YOU and should be received within 24-48 hours for clients with direct deposit and 5-7 business days for clients reimbursed by cheque.

NEW PATIENTS WITHOUT DENTAL COVERAGE

Payment is due AT THE TIME OF YOUR APPOINTMENT using one of the above. Yearly tax receipts are provided upon request. Payment plans or preauthorized credit card payments are accepted for large treatment plans and major dental treatment but provided under the discretion of the office and with a signed financial agreement.

PRIVACY POLICY

I hereby consent to the collection of personal data for myself and/or any minor of which I am legally responsible for. I permit the use of said information to be used in any manner or purpose in the course of or relating to treatment and to this dental practice. I accept responsibility for all fees charged for treatment rendered whether covered by insurance or not and in addition I consent to the submission of my dental claims electronically to my insurance provider. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry and Dental Hygiene Acts of Ontario and to any insurer or other payment organization who may be responsible for payment of all or part of any treatment or services provided.

In compliance with Canada's Anti-Spam Legislation, we, have your consent in order to continue communicating with you electronically.

Signature of Patient/Guardian

Date

Witness

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> (519) 442 3222
> cobblestonedentalcare.com