

Dr. Mr. / Ms. / Mrs. / Miss _____
 Address _____
 City _____ P Code _____
 Phone: Residence _____ Cell _____ Business _____
 Birthdate: _____ Day _____ Month _____ Year Sex _____
 Parents or Spouses Name _____
 Employer _____

INSURANCE INFORMATION

Insurance Company 1 _____ 2 _____
 Deductible _____ Spouse Date of Birth _____

PRIMARY CARRIER

SECONDARY CARRIER

Name of Insured _____
 Contract or GRP # _____
 Cert or ID # _____
 Div/Section # _____
 c/o Basic _____ c/o Major _____
 Welfare / AISH / Non Insured Health Benefits _____
 Card # _____
 Status # _____
 Driver's License # _____
 E-mail: _____ SIN # _____
 Family Doctor's Name _____
 How did you hear about our office? _____

| | Yes | No |
|---|--------------------------|--------------------------|
| Have you been under the care of a physician lately? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a serious illness or operation? Specify _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| HAVE YOU HAD ANY TYPE OF ALLERGY (ie. medication, latex or rubber), HAY FEVER OR ASTHMA? Specify _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had any allergic reaction to jewelry? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had an unpleasant anaesthetic experience or reaction to a drug? (Freezing) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been warned against taking any specific medication i.e. penicillin, aspirin, novocaine? Specify _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you on drugs or medication at present? Specify _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a shortness of breath, pains in chest? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had radiation treatment to your face or jaw? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you bleed a long time after a cut or dental extraction? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Springhetti Centre for Dental Health & Aesthetics
Financial Policy

The financial policy at the Springhetti Centre for Dental Health and Aesthetics is as follows:

The Springhetti Centre is a non-assignment office. That means we will send in your insurance claims to your carrier either electronically or through the mail, and we ask that your insurance carrier reimburse you. When claims are processed electronically the patient usually receives their payment within a week, especially if paying by Visa or MasterCard. Our patients pay us on the day of their visits by using either:

- 1) Visa.
- 2) MasterCard.
- 3) Debit Card.
- 4) American Express.
- 5) Cash.

If the patient wants an estimate for procedures such as fillings, periodontal therapy, or root canals, we will provide one.

We will provide you with a written estimate for any major treatment required, for example; Crowns, Bridges, Dentures, and Smile Design. **With the understanding that it is only an estimate and that changes to treatment can occur during clinical procedures.** Patients must know what their maximum coverage is for Major and Basic treatment per year. We will ask the patient to sign the estimate before proceeding with the treatment. Springhetti Dental Centre will do everything that it is possible to maximize the patients' benefits.

If a patient wants to know what amount of the treatment their insurance carrier will reimburse them for, then we will send a pre-estimate to their insurance. If the insurance carrier only responds to the patient then we ask that the patient contact our office when they receive it. Please do not allow your insurance company to dictate the health and wellbeing of your mouth.

We will always work with you to help make your dental needs and desires affordable to you.

Just a Reminder Springhetti Dental Centre Requires 2 Business Days Notification to Confirm or Make Any Changes to the Existing Appointments. \$50.00 or \$100.00 Fee May Apply for Short Notice Cancellation or No Show.

Patient Print Name: ----- Witness Print Name: -----

Patient Signature: ----- Witness Signature: -----

Date: -----