Sunnyside Health Centre
Family Dentistry

Dr. Ralph Blatt Dr. Robyn Blatt Dr. Allison Blatt

PATIENT INFORMATION

Name _____ Birth Date _____ Home Phone _____
Address _____ City _____ Province _____ Postal Code _____
Email address _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Common Law
Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ Province _____ Postal Code _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
If Patient is a Student, Name of School/College _____ City _____ Province _____
Whom May We Thank for Referring you? _____
Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of the Person Responsible for this Account _____ Relation to Patient _____
Address _____ Home Phone _____
Birth Date _____
Employer _____ Work Phone _____
Currently a Patient in our Office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____
Birth Date _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ Province _____ Postal Code _____
Insurance Company _____ Group# _____ Union or Local# _____
Address _____ City _____
How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____
Birth Date _____ Date Employed _____
Employer _____ Work Phone _____
Employer Address _____ City _____ Province _____ Postal Code _____
Insurance Company _____ Group# _____ Union or Local# _____
Address _____ City _____
How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

OVER

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DENTAL HISTORY

Reason for today's visit _____
Former Dentist _____
Address _____
Date of last dental visit _____ Date of last dental X-rays _____

Check (✔) if you have had any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity to biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____
Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____
Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____
(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✔) if you have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
  Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problem
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List Medications you are currently taking:

_____
_____

ALLERGIES

_____
_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge . I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of patient or parent if minor Date

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Patient Policy Agreement

1. Our fees are based on the current year Fee Schedule of the Ontario Dental Association.
2. Fees must be paid on the day of the treatment. For your convenience, we do accept credit cards. If extensive work is required, we will discuss a payment pattern to more closely suit your situation. Do not hesitate to discuss our fees with us if you have any questions.
3. Assignment of insurance is accepted provided that:
    - The appropriate insurance forms and information booklet are brought in at the time of the appointment
    - Any amounts NOT COVERED by the insurance company are paid at the time of the appointment.
    - Your insurance company will send the cheque to us.
    - We ask that a credit card number be left on file with us, in case services thought to be covered by your insurance are not. We will bill your credit card for these services.

    - **Credit card (V, MC) #_____exp._____**

4. However, our professional services are rendered to you, not to the insurance company. You are therefore ultimately responsible to us for the payment for treatment rendered.
5. The goal of our practice is that you attain the highest level of dental health possible for you. Part of your contribution to achieving your optimum dental health is making and keeping scheduled appointments. Missed appointments may affect other patients in need of treatment.
6. As appointments are reserved exclusively for you alone, we require 2 business days notice for cancellations or you may be charged for the missed appointment. The fees for missed visits with the dentist or the hygienist are as follows: $90 per hour, $70 per 45 minutes, $50 per 30 minute visit.
7. We will attempt to remind you of your appointment a day or two in advance, however, it is your responsibility to keep your appointments.

_____
Patient's Signature

_____
Date