Date: _____ PID # _____
(for office use)

WELCOME TO APPLEWOOD VILLAGE DENTISTRY

New Patient Registration Form

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form. **Digitally completed forms must have a signature by hand.**

PERSONAL INFORMATION

Last Name: _____ First: _____ Initial: ____ Dr. ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯

The patient is an: ◯ Adult ◯ Child ◯ Adult under guardianship Name of Guardian: _____

Address: Street _____

Apt # _____ City _____ Province _____ Postal Code _____

Home Phone: _____ Cell Phone: _____ Bus. Phone: _____ Ext. ____

E-mail address: _____

Employer: _____ Occupation: _____

Date of Birth: M _____ D ____ Y _____ Age: _____ Sex: F ◯ M ◯

Marital Status: Name of Spouse: _____

Are other family members patients at our office? YES ◯ Names: _____

Whom may we thank for referring you? _____

Family Physician: _____ Phone: _____

Medical Specialist: _____ Phone: _____
(if presently under care)

Usual pharmacy: _____ Location: _____ Phone: _____

In case of emergency, please contact: _____ Phone: _____

DENTAL INSURANCE

Do you have current dental insurance coverage? Circle one:

◯ Yes, hand over insurance card/s to receptionist.

◯ No, name person financially responsible for your account or self.

Last Name: _____ First: _____ Initial:____ Phone: _____

Address: Street _____ Apt # _____ City _____ Province _____ Postal Code _____

DENTAL HISTORY

Date of your last dental visit? _____ Last dental cleaning? _____ Last x-rays? _____

1. Which dental issue or problem in your mouth is your first priority? _____

2. Are you having regular dental visits? _____

3. How often do you brush your teeth? _____ Do you feel that you have bad breath? _____

4. Do you use dental floss, proxabrush or water-pik? _____ How often? _____

5. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? _____

6. Are any of your teeth sensitive to heat, cold, sweets or pressure? _____

7. Do you consume a lot of pop or juice or coffee? _____ Do you sip for long periods of time? _____

8. Do you think you clench or grind your teeth, either awake or asleep? _____

9. Do you have any emotional concerns about having dental treatment? _____

10. Are you unhappy with the appearance of your teeth? _____ What would you like to see changed? _____

HEALTH HISTORY

1. Are you being treated for any medical condition at present or within the past year?
   If yes, please explain: _____

2. Indicate which of the following you presently have, or ever had: (Please check all that apply)

◯ Asthma	◯ Diabetes	◯ Heart Disease
◯ Bronchitis	◯ Kidney Disease	◯ Angina/Chest pain
◯ Emphysema	◯ Thyroid Disease	◯ Shortness of breath
◯ Lung Disease	◯ Glandular Disorders	◯ Pacemaker
◯ Epilepsy or Seizures	◯ Organ Transplant/Medical Implant	◯ HIV
◯ Hepatitis	◯ Joint replacement	◯ Hepatitis B
◯ Jaundice	◯ Stomach/Intestinal Problems	◯ Hepatitis C
◯ Liver Disease	◯ Stomach acid reflux	◯ Cancer/chemotherapy/radiation therapy
◯ Tuberculosis	◯ Ulcers	◯ Depression/Anxiety/Mental issues

3. List any PRESCRIPTION or NON-PRESCRIPTION drugs you are taking or have recently taken (including birth control pills):

_____

_____

4. Are you on any blood thinners currently? _____ Are you on Aspirin or Plavix? _____

5. Have you ever had any adverse or unusual reaction to any medications or injections? Please explain:
   (e.g. penicillin, or other antibiotics, aspirin, codeine, local anesthetic ("dental freezing")? _____

_____

7. Do you have any allergies (e.g. hay fever, food allergies, latex/rubber or metal allergies)? _____

8. Do you, or did you smoke? _____ If yes, Frequency & for how long? _____
How many alcoholic drinks per week? _____ Use Recreational Drugs? _____

9. **WOMEN ONLY:** Are you pregnant? ____ If pregnant, delivery date? _____ Are you breast feeding? _____

10. Any other medical issues that you wish to tell us about? _____
Or do you wish to speak to the doctor privately about any problem or medical condition?

_____

_____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. Should there be any change in my health status in the future, I will advise this dental office.
I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____

(signature) Patient/Parent/Guardian **(Print Name)**

_____ _____

Reviewed by Treating Dentist: **Date:**

APPOINTMENT POLICY

We require 48 hours notice for appointment cancellations.
Appointment changes without adequate notice may be subject to a fee of up to $50.00, payable by the patient and not the insurance company.

FINANCIAL POLICY

Applewood Village Dentistry is a general dental practice. Our fees are in accordance with the Ontario Dental Association's current suggested fee guide. If you have dental insurance we will gladly submit electronically a pre-determination (estimate) and or dental claim for you. We will accept direct payment from the insurance company; however, the portion not covered by the insurance company will be due at the time of the appointment, including any deductibles. We will accept VISA, MASTERCARD, INTERAC, and CASH. Acceptance of a personal cheque is at the discretion of the office. Placement of a "stop payment", or cheques returned due to insufficient funds are subject to a $25.00 service charge. Any further collection costs will be the responsibility of the patient or the person responsible for the account. We ask that a family designate one member to be account holder for entire family, usually the insurance-holder.
Any unpaid fees remaining on an account after 30 days will incur interest @1.5% per month, and any balances not paid by the end of 90 days from date of service will be handed over to a licensed collection agency. Any and all additional fees and interest charged by the agency will be billed to the patient's account as well. In event legal action should become necessary to collect an unpaid balance due for medical services rendered to my family or me I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

_____ _____

(signature) Patient/Parent/Guardian **(Print Name)**

AUTHORIZATION TO RELEASE INFORMATION

I understand that Applewood Village Dentistry is equipped to send/receive dental insurance claims electronically using the CDANet network and the iTrans Services. I understand that these services are provided to me as a benefit by Applewood Village Dentistry and where the claims cannot be submitted electronically, they will be submitted by mail. Where claims cannot be submitted or when a claim is rejected by the insurance carriers, the responsibility for payment for services rests with me.
I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist.
This authorization shall continue in effect until the undersigned revokes the same.

(signature) Patient/Parent/Guardian **Date**

AUTHORIZATION TO ASSIGN MY BENEFITS TO THE DENTIST

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Vipul G. Shukla or Dr. Sherin Shukla of Applewood Village Dentistry and authorize payment directly to him/her.
This authorization shall continue in effect until the undersigned revokes the same.

(signature) Patient/Parent/Guardian **Date**