WELCOME TO OUR OFFICE

Mr ☐ Mrs☐ Ms☐ Dr☐ Date of Birth DD_____ MM_____ YYYY_____ Male☐ Female☐

First Name:_____ Last Name:_____

Address: _____ Apt/Unit: _____

City:_____ Postal Code:_____

Tele: Residence _____ Business _____ Ext _____

Cell Phone _____ Email _____@ _____

Best method(s) of contact:Home ☐ Business☐ Cell☐ Email☐ Best time(s) to contact you:AM☐ Afternoon☐ PM☐

Emergency contact: Name _____ Telephone _____

Relationship _____

How did you hear about us? (Check all that apply)

Internet ☐ Website/search engine: _____

Brochure ☐ What caught your eyes: _____

Word of Mouth ☐ Name of person: _____

Walked/drove by ☐

Public Health ☐ Ontario Works☐ ODSP☐ CINOT☐ Healthy Smiles☐

Insurance Information #1

Insured Member: First Name_____ Last Name _____

Member's Date of Birth DD_____ MM_____ YYYY_____ Insurance Company _____

Policy/Contract # _____ Certificate/Member ID _____

Permitted Member's Signature _____

Insurance Information #2

Insured Member: First Name_____ Last Name _____

Member's Date of Birth DD_____ MM_____ YYYY_____ Insurance Company _____

Policy/Contract # _____ Certificate/Member ID _____

Permitted Member's Signature _____

The office may use electronic forms of submission for making claims. I, stated above, certify that I and my family permit Dr. Mark Joe and Associates to collect all insurance payments for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the doctor to release all information necessary to secure the payments of benefits.

Medical History

Please check any of the following that apply to you:

□ AIDS	□ Drug addiction	□ HIV positive	□ Respiratory problems
□ Allergies, seasonal	□ Emphysema	□ HPV	□ Rheumatic fever
□ Anemia	□ Excessive bleeding	□ Jaundice	□ Rheumatism
□ Arthritis	□ Fainting	□ Jaw joint pain	□ Scarlet fever
□ Artificial heart valve	□ Glaucoma	□ Kidney disease	□ Seizures
□ Artificial joints	□ Heart conditions	□ Liver disease	□ Snoring/Sleep apnea
□ Asthma	□ Heart lesions, congenital	□ Low blood pressure	□ Stomach problems
□ Blood disease	□ Heart murmur	□ Mitral valve prolapse	□ Stroke
□ Bruise easily	□ Heart surgery	□ Nervousness/Depression	□ Thyroid disease
□ Cancer	□ Hepatitis A	□ Pacemaker	□ Tuberculosis
□ Chemotherapy	□ Hepatitis B	□ Phen fen (1 month+)	□ Ulcers
□ Diabetes	□ Hepatitis C	□ Pregnant, currently	□ Venereal diseases
□ Dizziness	□ High blood pressure	□ Radiation (head/neck)	□ Other

Do you have any allergies?

□ Aspirin	□ Codeine	□ Latex	□ Local anesthetic
□ Penicillin	□ Other _____		

Do any of the following conditions apply?

Have you ever had a joint replacement? Yes □ No □ If yes, when?_____

Has your physician ever told you to take antibiotics prior to dental procedures? Yes □ No □

If so, why? _____

Have you ever experienced complications following a medical or dental procedure? Yes □ No □

If yes, please describe. _____

Is there anything else you think we should know regarding your medical history (any surgeries)? Yes □ No □

If yes, please describe. _____

Are you currently under a physician's care? Yes □ No □

If yes, what for? _____

Are you taking any medications or vitamins? Yes □ No □

If yes, please specify _____

Family Physician's Name: _____ Physician's Phone #: _____

Dental History

Please check any of the following problems that may apply to you.

Sensitivity (hot, cold and/or sweet) □
Headaches, earaches or neck pain □
Teeth or fillings breaking □
Bleeding, swollen or irritated gums □
Bad breath or bad taste in your mouth □
Tooth pain or discomfort while chewing □
Jaw joint pain (clicking/cracking) □
Grinding or clenching teeth □
Loose, tipped or shifting teeth □

Do you have or have you had any of the following?

Dentures □
Braces □
Partial dentures □
Periodontal (gum) treatments □

Please share the following dates:

Your last dental cleaning MM_____ YYYY_____
Your last oral cancer screening MM_____ YYYY_____
If you could whiten your teeth for a cost anyone could afford, would you do it? □ Yes □ No
Do you smoke or use chewing tobacco? □ Yes □ No
If yes, how often? _____ For how long? _____

If you could change your smile, you would...

Make your teeth brighter □
Close spaces □
natural, tooth coloured fillings □
Replace missing teeth □
Have a smile makeover □
Make your teeth straighter □
Replace black metal fillings with □
Repair chipped teeth □
Replace old crowns that don't match □

On a scale of 1 to 10, with 10 being the highest rating…
How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

How do you rate your present dental health?
1 2 3 4 5 6 7 8 9 10

Privacy Policy Information

I certify that I have read, understood and accurately completed the personal, dental and medical histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me. If required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided.

Consent for Collection, Use and Disclosure of Personal Information

I agree that Dr. Mark Joe and Associates has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act, 2004.

Date: _____ Patient/Parent Signature: _____

Payment Options and Agreement

I _____agree to pay for the recommended dental treatment as follows:

□ Fee for service (pay as you go)

Name of person paying and method _____

Visa / Mastercard # _____ _____ _____ _____ Expiry____ /_____

3-Digit Security Code: _____

□ 3rd Party Financing

Company _____ ID/Reference #_____

□ Dental Insurance with a current credit card on file for any difference

Name on the credit card _____

Visa / Mastercard # _____ _____ _____ _____ Expiry____ /_____

3-Digit Security Code: _____

Signature of cardholder _____

I understand that I am responsible for full payment of services rendered at the time of treatment.

I understand that my credit card will be billed automatically for any differences that are not covered by my insurance company.

The efficient operation of our office benefits all patients. Please help us in providing the best of service by remembering that your appointment is a time reserved for you. Therefore, at least **2 business days** must be given if cancellation is absolutely necessary. Patients will be charged for unreasonable last minute cancellations or no-shows. *This is not covered by your insurance*.

Date _____ Patient/Parent Signature_____

Witness _____

We will make a courtesy call to you prior to charging your card. If after 5 business days, you do not respond we will charge your card and send you a receipt.