PATIENT INFORMATION

LAST NAME _____ BIRTHDATE: M_____D_____Y_____

FIRST NAME _____ MARITAL STATUS: Single Married Divorced Common Law Widow SEX: M F

PREF. NAME _____ PARENT OR GUARDIAN IF CHILD _____

ADDRESS _____ HOME PHONE _____ EMAIL _____

_____ WORK PHONE _____ CELL PHONE _____

POSTAL CODE_____ HOW DID YOU HEAR OF OUR OFFICE? _____

Name of Previous Dentist _____ **Occupation** _____

INSURANCE	Primary Plan(Self)	Secondary Plan(Spouse)
1) INSURANCE COMPANY NAME	_____	_____
2) EMPLOYER NAME	_____	_____
3) MEMBER'S NAME	_____	_____
4) MEMBER'S BIRTHDATE	_____	_____
5) GROUP OR POLICY #	_____	_____
6) ID OR CERTIFICATE #	_____	_____
7) Coverage	_____% basic _____%major	_____%basic _____% major
8) Any Limits or Maximums?	_____	_____

MEDICAL HISTORY

1)	Have you been under the care of a physician in the past two years?	YES NO _____
2)	Have you ever had a serious illness and required admission to a hospital?	YES NO _____
3)	Have you ever had any type of allergies or a reaction to a drug?	YES NO _____
4)	Are you taking any medication at present? Please list:	YES NO _____
5)	Have you ever fainted?	YES NO _____
6)	Do you bleed easily or do cuts in your skin stay open a long time?	YES NO _____
7)	Do you have chest pain or difficulty breathing?	YES NO _____
8)	Have you ever had Heart Disease or High Blood Pressure?	YES NO _____
9)	Have you ever had Diabetes, Kidney disease, hepatitis or Epilepsy?	YES NO _____
10)	Have you ever had any injury, surgery or radiation to the face or jaw?	YES NO _____
11)	Are you or have you ever been a smoker?	YES NO _____
12)	Women-could you be pregnant?	YES NO _____
13)	Are you presently in good health?	YES NO _____
14)	Name of physician? _____	phone # _____

SIGNATURE _____ **DATE** _____

HARMONY DENTAL STUDIO'S OFFICE POLICIES

INSURANCE AND PAYMENT

· Harmony Dental Studio is a 'Non Assignment Office'. What this means is that we ask for payment at the time of treatment, this allows us to focus on your dental care and quality of service. It is the responsibility of your dental insurance carrier to directly reimburse you for the portion of the procedure that is covered, as the actual contract is between you and the insurance company. Due to new privacy issues, some insurance companies will not discuss your coverage with a dental office. Usually insurance companies will reimburse you within 3-15 days which is much faster than payment to the dentist which can sometimes take up to 6 months!

It is our duty to guide you and give you treatment options that coincide with what you actually require. Your individual needs may be different from what your plan covers. Accepting your own claims means you are taking an active interest in your own dental health and becoming a better informed consumer. We would be happy to assist you with claims, send out predeterminations and provide you with estimates for future work. As a courtesy to you we would like to give you the option of accepting 'assignment' for your first visit as you may have been unaware of our policy. Please speak to the receptionist if you would like to take advantage of this option.

APPOINTMENTS

· 48 working hours notice is required to reschedule a booked appointment. If enough notice is not given there may be a fee of $50 per ½ hour of missed appointment time applied to your account. Your appointment time is specifically reserved with you in mind.

· We know your time is valuable and we will make every effort possible to stay on schedule and in return we would appreciate our patients to arrive at their scheduled time as well. If more than 15 minutes has lapsed unfortunately we may have to reschedule your appointment.

REFERRALS

· We continue to accept new patients and encourage you to refer your friends and family to us. We very much appreciate your support and to thank you we do have a reward system in place!

SIGNATURE _____ **DATE** _____

CHILDS DENTAL HEALTH HISTORY (UNDER 12)

Is this your child's 1st visit to the dentist? Yes No

If No – When was the last dental visit? _____

What was done then?

- Exam
- Polish
- X-rays
- Fluoride
- Dental work
- Not sure

Do you have any specific dental/oral health concerns? _____

How often does your child brush his/her teeth? _____

How often does your child floss his/her teeth? _____

Is your child co-operative when brushing/flossing his /her teeth? Yes No

Is your child on a special diet? _____

Please check all that apply:

- Uses bottles
- Uses a pacifier (previous/current)
- Thumbsucker (previous/current)
- Mouthbreather
- Grinding
- Trauma to teeth/jaws
- Gagging

Is there anything else you feel we should know about your child? _____

_____

Thank you for completing this form. It will help us work together to provide a healthy smile for life!