Medical History

Date: Date of Birth: Medical Physician:

Name: Preferred Name: Occupation:

*****ALL INFORMATION COLLECTED IS STRICTLY CONFIDENTIAL. IN ORDER FOR USE TO SAFELY PROVIDE ANY DENTAL TREATMENT, IT IS IMPERATIVE THAT WE ARE AWARE OF YOUR HEALTH STATUS AND ANY CURRENT USE OF MEDICATIONS/DRUGS (THIS INCLUDES PRESCRIPTION, NON-PRESCRIPTION, ILLEGAL DRUGS)*****

1. Are you having pain or discomfort at this time? YES NO
2. Do you feel nervous about having dental treatment done? YES NO
3. Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax, or Zometa, within the past twelve years? YES NO
4. Have you used any illegal drugs in the last six months? YES NO
   If YES please indicated
5. Do you smoke cigarettes or use tobacco products? YES NO
6. Do you have or have had any of the following (please circle)

High Blood Pressure	Hepatitis	Bleeding Disorder	Heart Attack	Coronary Bypass
Glaucoma	Arrhythmias	Liver Disorders	Chemical Dependency	Pacemaker
Alcoholism	Stroke	Respiratory Problems	Heart Murmur	Heart Defect
Diabetes	Kidney Problems	Osteoporosis	Epilepsy	Mitral Valve Prolapse
Arthritis	Tuberculosis	Herpes	Blood Transfusion	Cancer
Artificial Joint	AIDS/ HIV Positive	Psychiatric Treatment	Hemophilia	Heart Valve Replacement

7. Have you had any other serious illness not listed above? Yes No
   If yes, please describe.
8. Do you have any allergies or sensitivities to any of the following:
   Penicillin Erythromycin Tetracycline Sulfa Codeine Aspirin Latex Other
9. Please list ALL prescription medications/drugs
10. Please list ALL other medications/drugs (over-the-counter, non-prescription, supplements, herbal remedies, etc)
11. Have you ever had any unfavorable reactions to dental treatment? YES NO
    If yes please explain.
12. Do you premedicate with antibiotics prior to ALL dental appointments? YES NO
13. Have you ever had excessive bleeding requiring special treatment? YES NO
    If yes, please explain.
14. FEMALE PATIENTS: Are you trying to conceive, pregnant or nursing? YES NO
    Do you take birth control Pills? YES NO

Please read and sign below:
I authorize the dentists and the professional staff of Clover Hills Dental to consult with my physician to seek clarification on the effect of my previous or past medical or dental condition. I also authorize and consent to perform tests/x-rays and treatment as required. To avoid any misunderstanding regarding dental insurance, we want our patients to know that we are providing you with a service and billing your insurance provider to the best of our knowledge, however any unpaid portions that insurance was expected to pay will be your responsibility.

Date: **Printed Name:** **Signature:**

Staff Use Only: **Referral Source:**

Clover Hills Dental

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

(or Responsible Party if under the age of 19)

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Dr.	❑ Miss ❑ Ms. ❑ Mst.	Marital Status (circle one) Single / Mar / Div / Sep / Widowed / Common law
Is this your legal name? ❑ Yes ❑ No	Preferred Name:	E-Mail Address:			Birth date: DAY / MONTH / YEAR / / ❑ Male ❑ Female
Street address: (Include apt or unit number)		Home phone no.: ( )			Cell no.: ( )
City:	Province:	Postal Code:			Preferred Method of Contact: Cell / Home / E-mail
Social Insurance Number:	Employer / Occupation:				Employer phone no.: ( )
Referred by (please check one box): ❑ Walk by		❑ Staff	❑ Door Hanger		
❑ Yellow Pages	❑ Newspaper Ad	❑ Postcard	❑ Website	❑ Sign	❑ Other (Please explain)
Other family members seen here:					

INSURANCE INFORMATION

Primary Holder's Name	Birth date: / /	Employer:	Insurance Company Name:
Policy Holder's Address & Phone Number (if different than above)	Relation to Insured	Certificate/ID #:	Group/Plan/ Policy #:
Secondary Holder's Name	Birth date: / /	Employer:	Insurance Company Name:
Policy Holder's Address & Phone Number (if different than above)	Relation to Insured	Certificate/ID #:	Group/Plan/Policy #:

I authorize release, to my dental benefits plan administrator and CDA net, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of service described to the named dentist. I hereby assign my benefits, payable from claims submitted electronically, to Dr Bhullar and / or Dr. Henne and authorize payment directly to him/her.

_____ _____

Signature of patient, parent or guardian Date

Clover Hills Dental

Family & Cosmetic Dentistry

It is our goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. To help us best serve your dental needs, please note our office policies.

Cancellation Policy

Our clinic requires a minimum of 2 business days notice if an appointment must be cancelled. A short notice cancelled appointment ***can adversely affect many other patients, especially those who are suffering or are in pain***. If less than 2 business days notice is given to cancel an appointment or no notice is given, a fee of $94.00 will be assessed.

In the event that a patient does not "*show up"* on a second occasion, the practice policy is to ask that patient to find a different practice. Our administrative staff will transfer the patient's records to another dentist of your choice.

Please note insurance companies do not cover any fees associated with missed or cancelled appointments; therefore payment is the patient's responsibility prior to re-scheduling.

Exceptions will be made for illness or personal tragedy.

Please initial that you have read and understand these terms _____.

Payment Policy

Payment is due upon completion of treatment.

Patients with Insurance benefits: *** Please read below***

Dental insurance is an agreement between your employer, yourself and your insurance company. We work with most insurance companies and always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. Due to the Canadian Privacy Act that has evolved through the years to protect your privacy, most insurance companies will release very limited information to us. Insurance companies also will *not* give us information on services billed by any other dental office. We will be happy to handle the first submission to your insurance company (primary and secondary if applicable), however if we do not receive payment within 60 days you will become responsible for the outstanding balance and any further negotiations with your insurer.

We do our best to provide you with an accurate estimate; however you are responsible for any balance not paid by insurance. Please initial that you have read and understand these terms_____.

We at Clover Hills Dental look forward to taking care of your oral health needs and welcome you to our office.

I have read the above office policy of Clover Hills Dental and understand my responsibilities as a patient or a responsible party.

_____

Print Name ***Signature*** ***Date***

Staff Initials_____