BURL Oak CENTRE DENTISTRY

Reviewed by _____

Patient Registration Form

☐ Mr. ☐Mrs. ☐Ms. ☐Miss/Master First Name_____ Last Name: _____

Date of Birth:_____ Gender: ☐Male ☐Female

Address: _____ City: _____ Postal Code: _____

Home Tel: _____ Work: _____ext. _____ Cell: _____

E-mail address: _____

☐ I consent to receiving electronic communications from Burloak Centre Dentistry, such as appointment confirmations, newsletter, and special offers. I can opt out of this at any time.

Best Time To Contact You: ☐ Morning ☐ Afternoon ☐ Evening
Best Method To Reach You: ☐ E-mail ☐Home # ☐Cell #

How did you hear about us?

☐ A friend or ☐ family member named: _____

☐ Internet Search ☐ Flyer Ad ☐Yellow Pages ☐Sign ☐Other_____

Emergency Contact: In case of an emergency, who should we call?

Name: _____ Relationship to you: _____

Home Tel #: _____ Work Tel #: _____ Cell #: _____

Financial Responsibility: **If you are under the age of 18, please indicate the following:**

☐ I am responsible for my account - OR - ☐ The following person is responsible for my account:
Name: _____ Relationship to you: _____

Address: _____ City: _____ Postal Code: _____

Telephone numbers: Home: _____ Work _____ext. _____ Cell: _____

Insurance Coverage

Primary Insurance

Name Of Insured:_____

☐ Male ☐ Female Date Of Birth: _____

Employer: _____

Insurance Company:_____

Group/ Plan/ Policy #:_____

ID / Certificate #: _____

Secondary Insurance

Name Of Insured:_____

☐ Male ☐ Female Date Of Birth: _____

Employer: _____

Insurance Company: _____

Group/ Plan/ Policy #:_____

ID / Certificate #: _____

Appointment Cancellations

Cancellation Charges: I understand that when an appointment is booked for me, the staff time is reserved for me. The equipment and materials are set up for me. If I need to change or cancel an appointment, I will provide 2 business day's notice (except in emergency situations). I understand that without 2 business day's notice, a charge may be applied. The amount charged will depend on the length of the appointment.

Initial To Signify That You Understand This Policy: _____

Medical History:

Do you currently have, *(or within the last 6 months, had)* any of the following?

- ☐ AIDS/ HIV
- ☐ Allergic to: _____
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder: _____
- ☐ Bronchitis
- ☐ Cancer
- ☐ Circulation problems
- ☐ Congenital Heart Lesions
- ☐ Crohn's Disease
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glandular disorders
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Rhythm disorder
- ☐ Heart Surgery
- ☐ Hepatitis A B C _____
- ☐ High Cholesterol
- ☐ Hyper/hypo Glycemia
- ☐ Inflammatory bowel disease
- ☐ Mitral Valve Prolapse
- ☐ Migraines
- ☐ Blood Pressure ☐ High ☐ Low
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Malignant Hyperthermia
- ☐ Mental Disorder
- ☐ Nervous System Disorder
- ☐ Organ Transplant/Medical Implant
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever (Scarlet Fever)
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Ulcers
- ☐ _____
- ☐ _____

Usual Blood Pressure: _____/_____ (if known)

For Women: Are you currently Pregnant? ☐ Yes ☐No
Due Date: _____

Are you under the care of a Medical Specialist? Y N Type_____ **Name** _____

Medications - Please List Your Regular Medications Below:

_____

_____

_____

Have you been hospitalized or required emergency medical care in the last two years? ☐ No ☐ Yes, details below

_____

Name of your physician:_____ Tel #: _____

Dental History & Concerns: Mark the areas that apply, and if desired, use the lines to provide additional details.

When was your last dental visit? _____ Name of dentist: _____

What did you like about your previous dental office? _____

Anything you disliked about your previous dental office? _____

Do you need sedation to make your visits comfortable? _____

□ Do your gums bleed at all when you brush your teeth? _____

□ Do you experience a bad taste or odour in your mouth? _____

□ Do you feel your gums are shrinking, or your teeth are getting longer? _____

□ Are any of your teeth sensitive to hot or cold? _____

□ Are any of your teeth sore to chew on? _____

□ Does your jaw click or crack or pop? _____

□ Do you want whiter teeth? _____

□ What are your goals for your visit today? _____

□ Do you have any other dental or oral health goals you want to discuss with us? _____

Sign below to confirm that all the information on this registration form is accurate to the best of your knowledge.

Patient Signature:_____ Date: _____

Insurance & Payment Policy

At Burloak Centre Dentistry, we make every effort to aid you in collecting the maximum benefit payable from your insurance company. Please review our insurance and payment policy.

Payment Options:

Our mission is to provide excellence in dentistry that meets your individual needs. **In order to reduce the cost of providing dentistry to our patients, payment is expected at the time of service.**

We are pleased to offer the following payment options:

☐ Option #1 **Non-assignment of benefits with payment in full.**

Payment is made in full by cash, interact, Visa, or MasterCard with non-assignment of your dental benefits. We will process your dental insurance claim for you and have the **insurance cheque sent directly to you** within 3-5 business days.

☐ Option #2 **Assignment of benefits secured with your credit card.**

We will accept assignment of your primary dental benefits and collect the co-payment at the time of service. We will provide you with a copy of any secondary insurance claims for you to submit. A credit card will be kept on file to process any payment not reimbursed to us within 30 days and a receipt of any charges will be mailed to you.

I hereby assign payment of my dental benefits directly to Burloak Centre Dentistry.

I hereby authorize Burloak Centre Dentistry to process payment to my credit card of any outstanding balance occurred during the course of dental treatment to keep my account current within 30 days.

Credit Card #:_____ Exp Date:____/____

Patient Name: _____

Patient Signature: _____

Date: _____