Main Street Dental Clinic

Patient Information

Patient Name: _____ Date:_____
Last   First   MI

☐ Male ☐ Female   ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date:_____ Sask Health # _____

Phone (Home): _____ (Work): _____ (Cell):_____ Email_____

Address: _____
Street   Apartment #

_____
City   Prov   Postal Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Have you ever had any of the following? Please check those that apply:

☐ AIDS	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies _____	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
_____	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Hay Fever	☐ **Pregnancy**	☐ Venereal Disease
☐ Artificial Joints	☐ Head Injuries	Due date:_____	☐ Codeine Allergy
☐ Asthma	☐ Heart Disease	☐ Radiation Treatment	☐ Penicillin Allergy
☐ Blood Disease	☐ Heart Murmur	☐ Respiratory Problems	OTHER:
☐ Cancer	☐ Hepatitis	☐ Rheumatic Fever	☐ _____
☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism	
☐ Dizziness	☐ Jaundice	☐ Sinus Problems	☐ _____
☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems	

- Have you ever had any complications following dental treatment?   ☐ Yes ☐ No
  If yes, please explain:_____

- Have you been admitted to a hospital or needed emergency care during the past two years?   ☐ Yes ☐ No
  If yes, please explain:_____

- Are you now under the care of a physician?   ☐ Yes ☐ No
  If yes, please explain:_____

- Name of Physician: _____ Phone:_____

- Do you have any health problems that need further clarification?   ☐ Yes ☐ No
  If yes, please explain:_____

List of Current Medications

_____
_____
_____
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Website ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street   City   State   Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
                        Last   First   MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
                        Street   City   State   Zip Code

Insured's Employer Name: _____

    Address: _____
                        Street   City   State   Zip Code

    Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
                        Last   First   MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
                        Street   City   State   Zip Code

Insured's Employer Name: _____

    Address: _____
                        Street   City   State   Zip Code

    Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Insurance Plan Name and Address: _____

Consent for Services

Welcome to our office. The office requires 2 business days for cancellations or changes to your appointment.

I am aware that Main Street Dental Clinic has a Privacy Code and I can ask to see the Code at any time. I Agree that Main Street Dental Clinic can collect, use and disclose personal information about me and dependents as outlined in the information about the office's privacy policies.

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically.
I herby assign my benefits, payable from claims submitted electronically, to the Provider of service and authorize payment directly to him/her.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party