Powassan Dental Centre **Dr. Terence K. Wong**

Chart #

Patient Information

Patient Name: _____ Today's Date: _____
Last First MI

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

Birth Date: _____ E-mail address:
dd / mm / yyyy

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

Address: _____
Street Apt

_____
City Province 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	☐ Cancer	☐ Mental Disorders	☐ Seizures/Epilepsy
☐ Allergy - Penicillin	☐ Diabetes	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Allergy - Latex	☐ Excessive Bleeding	☐ Organ Transplants	☐ Ulcers
☐ Other _____	☐ Fibromyalgia	☐ Pacemaker	OTHER
☐ Alzheimer's/Dementia	☐ Glaucoma	☐ Pregnancy (now)	
☐Anemia	☐ Head Injuries	Due _____	_____
☐ Anxiety	☐ Heart Disease or Recent Heart Attack	☐ Radiation Treatment	_____
☐ Arthritis		☐ Respiratory Problems	
☐ Artificial Joints	☐ Heart Murmur	☐ Rheumatic Fever	
☐ Asthma	☐ Hepatitis (A/B/C)	☐ Sinus Problems	
☐Blood Pressure (High/Low)	☐Kidney Disease	☐ Stomach Problems	☐ Need Pre-medication
	☐ Liver Disease	☐ Stroke	☐ Extreme Dental Anxiety

• Please list all prescription and non-prescription medications: _____

_____

• 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 for any on-going medical treatment? Yes / No

If yes, please explain: _____

• Name of Family Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes / No

If yes, please explain: _____

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

□ Dental Office □ Yellow Pages □ Website □ School □ Work □ Other _____

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Chart #

Employment Information

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

Employer Name: _____ Occupation: _____

Address: _____

Street City Province Postal Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? □ Yes □ No

Last First MI

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

Insurance Company Name: _____

Insured's Address (if different from previously mentioned) _____

Insured's Employer Name: (if different from previously mentioned) _____

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

Secondary (Only if you have insurance coverage through another source)

Name of Insured: _____ Is insured a patient? □ Yes □ No

Last First MI

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

Insurance Company Name: _____

Insured's Address (if different from previously mentioned) _____

Insured's Employer Name: (if different from previously mentioned) _____

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

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. The office reserves the right to refuse the use of personal cheques as a form of payment for these appointments.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms where possible. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I authorize release, to my dental benefits plan administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revoked the same.

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 (if applicable)