New Delhi Dental
Welcome

PATIENT NAME: MR./MISS/MRS./MS./DR./CHILD **Today's DATE:** _____

DATE OF BIRTH (DAY/MONTH/YEAR): _____ / _____ / _____ DRIVER'S LICENCE #: _____

EMAIL: _____

PARENT/GUARDIAN OF PATIENT: MR./MISS/MRS./MS./DR.

ADDRESS (HOME):

PHONE #: H#: W#: C#:

EMPLOYER:

BUSINESS ADDRESS :

PHONE:

Email:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

□ Another Patient, Friend Name:

□ Another Patient, Relative Name:

□ Doctor's Office

□ Yellow Pages

□ Website

□ Other

□ Newspaper

□ Mailers/flyers

IF MARRIED: (for contact information)

SPOUSE'S/PARTNER'S NAME: DATE OF BIRTH (DAY/MONTH/YEAR): _____ / _____ / _____

DRIVER'S LICENCE #: _____

ADDRESS (HOME):

PHONE #: H#: W#: C#:

DENTAL INUSRANCE INFORMATION:

PRIMARY INSURANCE INFORMATION:

Insured's Name: Insured's Employer: _____

Insurance Company: Policy #: _____

Certificate or I.D. #: Phone: _____

SECONDARY INSURANCE INFORMATION:

Insured's Name: Insured's Employer: _____

Insurance Company: Policy #: _____

Certificate or I.D. #: Phone: _____

New Delhi Dental

PATIENT MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT(S):

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME: _____ DAY-TIME PHONE: _____

RELATIONSHIP: _____ ALTERNATE PHONE: _____

NAME OF FAMILY DOCTOR: _____ PHONE: _____

ADDRESS: _____

NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALTY: _____ PHONE: _____

ADDRESS: _____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
□ Yes □ No □ Not Sure/Maybe

2. When was your last medical check-up? _____

3. Has there been any change in your general health in the past year? If yes, please explain.
□ Yes □ No □ Not Sure/Maybe

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.
□ Yes □ No □ Not Sure/Maybe

5. Do you have any allergies? If you answered yes, please list using the categories below:
□ Yes □ No □ Not Sure/Maybe

A) Medications (Penicillin, Codeine, ASA, ...etc)
B) Latex/rubber products
C) Other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
□ Yes □ No □ Not Sure/Maybe

7. Do you have or have you ever had asthma?
□ Yes □ No □ Not Sure/Maybe

MEDICAL QUESTIONNAIRE CONTINUED:

8. Do you have or have you ever had any heart or blood pressure problems? □ Yes □ No □ Not Sure/Maybe

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? □ Yes □ No □ Not Sure/Maybe

10. Do you have a prosthetic or artificial joint? □ Yes □ No □ Not Sure/Maybe

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? □ Yes □ No □ Not Sure/Maybe

12. Have you ever had hepatitis, jaundice or liver disease? □ Yes □ No □ Not Sure/Maybe

13. Do you have a bleeding problem or bleeding disorder? □ Yes □ No □ Not Sure/Maybe

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. □ Yes □ No □ Not Sure/Maybe

15. Do you have or have you ever had any of the following? Please check.

□ chest pain, angina	□ rheumatic fever	□ pacemaker	□ steroid therapy	□ seizures (epilepsy)	□ osteoporosis medications
□ heart attack	□ mitral valve prolapse	□ lung disease	□ diabetes	□ kidney disease	(e.g. Fosamax, Actonel)
□ stroke		□ tuberculosis	□ stomach ulcers	□ thyroid disease	
□ shortness of breath	□ heart murmur	□ cancer	□ arthritis	□ drug/alcohol dependency	

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? □ Yes □ No □ Not Sure/Maybe

17. Are there any disease or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) □ Yes □ No □ Not Sure/Maybe

18. Do you smoke or chew tobacco products? □ Yes □ No □ Not Sure/Maybe

19. Are you nervous during dental treatment? □ Yes □ No □ Not Sure/Maybe

20. **For Women only**: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? □ Yes □ No □ Not Sure/Maybe

To the best of my knowledge, the above information is correct::

PATIENT/PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

DENTIST SIGNATURE: _____ DATE: _____

DENTIST'S NOTES:

PATIENT DENTAL DATA

HISTORY WITH PREVIOUS DENTIST:

Previous DENTIST: _____

Address/Phone #: _____ Date of Last Visit: _____

Last Dental X-RAYS: DATE: _____ Type of X-rays taken: _____

Date of Last Dental Cleaning: _____ # of Cleanings per year: _____

Frequency of brushing: _____/day Frequency of flossing: _____/day Other Hygiene aids: _____

Reason why you left your previous dentist: _____

DENTAL CONDITION:

1. What is your chief complaint about your teeth?

_____

_____

2. How would you like us to help you?

_____

_____

3. Are you experiencing any discomfort or pain at this time?
4. Are you satisfied with the appearance of your teeth?
5. Are you able to eat and chew foods satisfactory?
6. Do you have headaches, ear aches or neck pain?
7. Do you have any problems with your jaw joints?
8. Do you have any problems with your bite?
9. Have you had serious trouble associated with previous dental treatment?

   If yes, please explain: _____

Please indicate any of the follwing conditions which apply to your dental health status:

□ Early tooth decay
□ TMJ, TMD, Jaw Joint problem
□ Loose Teeth
□ Difficulty opening widely
□ Nightguard, retainer
□ Periodontal Surgery
□ Root canals
□ Periodontal disease (pyorrhea)
□ Crowns &/or bridges
□ Sensitive teeth
□ Pain in jaw joint
□ Clenching, grinding of teeth
□ "Novocaine" or any anaesthetic adverse reaction
□ Bleeding gums
□ Orthodontic Treatment
□ Remeovable partial denture
□ Swelling on gum
□ Ear problems or ringing
□ Sore Teeth
□ Premedication required (by Dr.)
□ Other (please explain) _____

DDS Notes: _____

_____

RESPONSIBILITY AND CONSENT:

I hereby authorize and request the performance of dental services for myself or for: _____

_____

I also give my consent to any advisable and necessary dental procedures, medications or anaesthetic to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment.
These records may include study models, photographs and x-rays, which may be used for dental education and used in dental publications.
I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.
I also understand that the treatment estimate presented to me is only an estimate. Occasionally, additional treatment and its fee.
I believe the information given in the six pages of this medical and dental history to be true to the best of my knowledge.

Signature of Patient or Guardian: _____

Signature of DDS: _____

Date: _____

Dr. Archana Jairath Dentistry Professional Corporation **FINANCIAL ARRANGEMENTS**

WELCOME TO OUR PRACTICE!

We would like to introduce you to our practice philosophy and commitment, which is shared by every member of our friendly and professional dental team. We offer our assurance of cleanliness and your safety, cutting edge technology, a relaxed and caring environment, with a dental team that is unconditionally dedicated to caring for our patients with the highest of quality and comfort. After all… "teeth are for a lifetime and deserve the best possible care."

FINANCIAL ARRANGEMENTS

We charge our fees according to the current Ontario Dental Association Fee Guide.

OPTIONS:

Please circle:

A)

1. **CASH**
2. **VISA, MasterCard, AMEX #** _____ **expiry date:** _____
3. **INTERAC**
4. **CHEQUE** (accompanied with SIN #, Driver's License & Credit Card back up)

B)

I wish to apply for your in-office **FUNDING PLAN (HealthSmart)**; I understand that upon approval, I will make 12 equal monthly payments.

I understand that I am responsible for the payment of my dental treatment, at the time service is rendered, regardless of insurance coverage, including any legal or other costs incurred in the collection of this account, if it becomes delinquent.

_____ _____ _____

Date Signature Staff Member

*Please note **5% Pre-payment** courtesy is applied to your account when major; implant and cosmetic services are not covered by insurance and paid in full when scheduling the appointment. (At least 2 business days prior to appointment)
*Also note a **2% interest charge** per month is applied on overdue accounts (over 30 days). A $30.00 service charge is applied on any **NSF/Returned Cheques**.

FINANICAL POLICY FOR ASSIGNMENT PA-

Please check the two boxes below:

¨ **"I have dental insurance and would like you to bill my insurance directly…"**If you have dental insurance and your policy does not cover a procedure at 100%, you are responsible to pay any known differences, such as: deductible, fee guide differences, co-payments...etc. The differences are to be paid on the day of treatment. It is your responsibility to establish what percentage of the proposed treatment is covered by your dental plan. Your insurance company will only give our office basic information. If you, the patient, receives the insurance payment you will promptly bring it in and sign it over.

¨ **"Please bill me for any unkown differences that may occur…"** I will pay known differences on the day of treatment.

_____ _____ _____

Date Signature Staff Member

Dr. Archana Jairath Dentistry Professional Corporation **CANCELLATION POLICY**

RESTORATIVE AND HYGIENE APPOINTMENTS

We ask for at least 48 hours advance notice for cancelling or rescheduling an appointment; otherwise, a $50.00 & UP fee may be assessed to your account.

***Note**:*All cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three parties- the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

_____ _____

Signature Date

ACKNOWLEDGEMENT AND RELEASE

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you , your employer and the insurance company, therefore we do not confirm insurance eligibility or predetermine recommended treatment. We are not preferred providers or members or have any association with any insurance organizations.

Collections

In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above aggress to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

_____ _____

Signature Date