WELCOME TO OUR OFFICE!

DATE _____

PATIENT I.D. # _____ EDI

MEDICAL ALERT (office use only)

PATIENT NAME:

To assist the dentist and ensure your well being while undergoing treatment in or office please answer the following questions in detail. Information will be considered confidential and for our records only. Please Print Neatly.
IF YOU HAVE ANY QUESTIONS OR DESIRE ASSISTANCE PLEASE ASK RECEPTIONIST

PATIENT INFORMATION

Name: _____ Prefers to be called: _____
(last) (first)

Address: _____
(street) (city) (prov.) (postal code)

Home Phone: _____ Business Phone _____ Ext: _____

Social Insurance: _____ Date of Birth: _____

School: _____

ACCOUNT INFORMATION

Name: _____ Prefers to be called: _____
(last) (first)

Address: _____
(street) (city) (prov.) (postal code)

Home Phone: _____ Business Phone _____ Ext: _____

Person Responsible for account: Self ☐ Other ☐ Name: _____

Address: _____

_____ Home Phone: _____

Social Insurance #: _____ Business Phone: _____

Occupation:

Employed by: _____ Phone: _____ Ext: _____

Spouse Employed by: _____ Phone: _____ Ext: _____

Dental Insurance: Yes ☐ No ☐

Primary Insurance:

Policy Holder: _____ Employer: _____

Insurance Information: _____

Amount of coverage: Basic _____% Denture _____% Crown and Bridge _____% Ortho _____% Perio _____%

Secondary Insurance:

Policy Holder: _____ Employer: _____

Insurance Information: _____

Amount of coverage: Basic _____% Denture _____% Crown and Bridge _____% Ortho _____% Perio _____%

In Case of Emergency Please Notify: _____ Relationship: _____

Phone: _____ Business Phone: ( ) _____ Ext: _____

Is any other member of your family or relative a patient at out office?

Sons _____

Daughters _____

Spouse _____ Other _____

Reason for today's visit: Examination ☐ Emergency ☐ Other ☐ _____

Whom may we thank for referring you to this office? _____

DENTAL HISTORY

PATIENT I.D. # | EDI |

MEDICAL ALERT (office use only)

PATIENT NAME:

LAST DENTAL VISIT	LAST DENTAL CLEANING	LAST DENTAL X-RAYS
Date	Date	Date

Are you suffering from pain now? ..... Yes ☐ No ☐

Are any of your teeth becoming loose? ..... Yes ☐ No ☐

Does food get caught between your teeth? ..... Yes ☐ No ☐

Is there any swelling or pain of your gums? ..... Yes ☐ No ☐

Do you notice any bleeding from your gums when you brush your teeth, or other? ..... Yes ☐ No ☐

Are any teeth sensitive to: cold ☐ hot ☐ sweet ☐ pressure ☐

Does your mouth tend to get dry? ..... Yes ☐ No ☐

Are you aware of bad breath or bad taste in your mouth? ..... Yes ☐ No ☐

Are you nervous about having dental treatment done? ..... Yes ☐ No ☐

Would you like to keep your natural teeth ..... Yes ☐ No ☐

Are you happy with the appearance of your teeth ..... Yes ☐ No ☐

What would you like to change with your teeth ..... Yes ☐ No ☐

Treatments Please check off the following treatment you have had.

A) Orthodontic Treatment? ..... Yes ☐ No ☐

B) Oral Surgery? ..... Yes ☐ No ☐

C) Periodontal (Gum) Treatment? ..... Yes ☐ No ☐

D) Teeth ground or bite adjusted? ..... Yes ☐ No ☐

E) Worn TMJ appliance? ..... Yes ☐ No ☐

F) Teeth extracted, resulting in complications? ..... Yes ☐ No ☐

Jaw Problems Do you have any of the following?

A) Pain (in jaw joints — ear, side face)? ..... Yes ☐ No ☐

B) Difficulty in opening or closing your mouth? ..... Yes ☐ No ☐

C) Have you ever had any implant surgery in one or both of your jaw joints? ..... Yes ☐ No ☐

D) If yes, who performed the surgery and when was it done? _____

Habits Do you

A) Clench or grind your teeth while awake or asleep? ..... Yes ☐ No ☐

B) Breath through your mouth while awake or asleep? ..... Yes ☐ No ☐

Is it important to you to keep your teeth clean? ..... Yes ☐ No ☐

How often do you brush your teeth? ..... Yes ☐ No ☐

Floss your teeth? ..... Yes ☐ No ☐

WELCOME TO OUR OFFICE!

At this office we would like to provide you with quality dental treatment and total patient care. Your treatment recommendations will be based on a thorough examination and diagnosis.

A written estimate can be sent to your insurance company to determine the extent of your coverage for specific procedures.

Your appointment time will be reserved especially for you. If you are unable to keep an appointment, we will require 24 hours notice, otherwise it will be necessary to charge for time lost.

I understand that I am financially responsible to the dentist for all treatment even if my insurance coverage may not be all-inclusive.

☐ I wish to pay each visit as services are performed. **CASH ☐ CHEQUE ☐ CREDIT CARD ☐**

☐ I wish to discuss special arrangements for payment.

Date: _____ Signature: _____

MEDICAL HISTORY

PATIENT I.D. # | EDI | **MEDICAL ALERT** (office use only)

PATIENT NAME:

Previous Dentist _____

Family Doctor _____ Date of last Doctor's visit _____

Current Medication _____

Are you presently under Doctor's care? Why _____

Have you had any serious medical problems in the last 5 years? What? _____

Have you been told to receive antibiotics before dental treatment? Yes ☐ No ☐

In order to avoid complications as a result of a change in your medical condition, it is important that you notify our office of these changes.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

Y	N		Y	N		Y	N	
☐	☐	Heart Murmur	☐	☐	Facial Surgery or Fractures	☐	☐	Anemia
☐	☐	Rheumatic or Scarlet Fever	☐	☐	Pain in Jaw Joints	☐	☐	Bleeding or Clotting Problems
☐	☐	High Blood Pressure	☐	☐	Sinus Trouble or Hay Fever	☐	☐	Blood Transfusion
☐	☐	Heart Attack	☐	☐	Cold Sores or Canker Sores	☐	☐	Chemotherapy or Cancer
☐	☐	Angina or Chest Pains	☐	☐	Thyroid Disease			
☐	☐	Pacemaker						
☐	☐	Coronary Bypass	☐	☐	Asthma	☐	☐	Stroke
☐	☐	Vascular Graft Surgery	☐	☐	Smoker	☐	☐	Epilepsy or Seizures
☐	☐	Heart Valve Disease	☐	☐	Tuberculosis	☐	☐	Fainting or Dizzy Spells
			☐	☐	Chronic Cough or Bronchitis	☐	☐	Developmentally Dysfunctional
☐	☐	HIV Positive	☐	☐	Shortness of Breath	☐	☐	Cerebral Palsy
☐	☐	Hepatitis	☐	☐	Cirrhosis of Liver	☐	☐	Senile Dementia
☐	☐	Cirrhosis of Liver	☐	☐	Emphysema			
☐	☐	Diabetes				☐	☐	Artificial Joint Replaced
☐	☐	Ulcers						
☐	☐	Alcoholism/Drug Dependancy						

Allergies:

☐ Penicillin ☐ Aspirin ☐ Other _____

☐ Codeine ☐ Local Anaesthetics _____ ☐ Erythromycin

☐ Latex / Rubber Products

For Women: Are you Pregnant? Yes ☐ No ☐ No. of weeks _____

COMMENTS RELATED TO ANY OF THE ABOVE: _____

_____

_____

AUTHORIZATION

I the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

Signature of Patient, Parent, Guardian, or Escort (Circle one)

Signature: _____ Date _____

MONTH DAY YEAR

bay DENTAL GROUP

PRIVACY, DISCLOSURE, & CONSENT

TO: Bay Dental Group and Bay Group Health Services

Information for our Patients

At Bay Dental Group, all professional dental services are performed by licensed members of the Royal College of Dental Surgeons ("Dental Professionals"), and all institutional health care services are performed independently by Bay Group Health Services, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Bay Dental Group and Bay Group Health Services are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Bay Group Health Services.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Bay Dental Group; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Bay Dental Group to provide the services you are requesting.

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided and accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office**. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Bay Dental Group, Bay Group Health Services, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Bay Dental Group and Bay Group Health Services in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Bay Dental Group and Bay Group Health Services are relying upon the information which I have provided being accurate and complete.

Print Name of ☐Patient ☐Parent ☐ Guardian	Signature of ☐Patient ☐Parent ☐ Guardian	Date

Reviewed by Bay Dental Group	Date

Canadian Life and Health Insurance Association Inc

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO | SPEC | PATIENT S OFFICE ACCOUNT NO

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT DIRECTLY TO HIM/HER

PATIENT

LAST NAME | GIVEN NAME

ADDRESS | APT

CITY | PROV | POSTAL CODE

DENTIST

PHONE NO

SIGNATURE OF SUBSCRIBER

FOR DENTIST S USE ONLY - FOR ADDITIONAL INFORMATION DIAGNOSIS PROCEDURES OR SPECIAL CONSIDERATION

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT
I ACKNOWLEDGE THAT THE TOTAL FEE OF $ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED
I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DUPLICATE FORM ☐

DATE OF SERVICE DAY	MO	YR	PRO-CEDURE CODE	INTL TOOTH CODE	TOOTH SUR-FACES	DENTIST S FEE	LABORATORY CHARGE	TOTAL CHARGES

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT S SHARE

CHEQUE NO | DATE

DEDUCTIBLE | PATIENT PAYS | PLAN PAYS

CLAIM NO

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE E & OE

TOTAL FEE SUBMITTED

INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER
IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2, AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE
*IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER

PART 2 — EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1 GROUP POLICY/PLAN NO _____ DIVISION/SECTION NO _____

EMPLOYER _____

NAME OF INSURING AGENCY OR PLAN _____

2 YOUR NAME (PLEASE PRINT) _____

YOUR CERT NO OR S I N OR I D NO

YOUR DATE OF BIRTH _____ DAY MONTH YEAR

PART 3 — PATIENT INFORMATION

1 PATIENT RELATIONSHIP TO EMPLOYEE/PLAN MEMBER/SUBSCRIBER _____

DATE OF BIRTH _____ DAY MONTH YEAR

IF CHILD INDICATE STUDENT ☐ HANDICAPPED ☐

IF STUDENT INDICATE SCHOOL _____

PATIENT I D NO _____

2 ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN W C B OR GOV T PLAN? NO ☐ YES ☐

POLICY NO _____ SPOUSE DATE OF BIRTH _____

NAME OF OTHER INSURING AGENCY OR PLAN _____

3 IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY NO ☐ YES ☐

4 IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OF PRIOR PLACEMENT AND REASON FOR REPLACEMENT NO ☐ YES ☐

5 IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSES? NO ☐ YES ☐

6 I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE

SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

DATE _____ DAY MONTH YEAR

PART 4 — POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE, SEE ABOVE*)

	DAY	MONTH	YEAR
1 DATE COVERAGE COMMENCED			
2 DATE DEPENDENT COVERED			
3 DATE TERMINATED			

4 CONTRACT HOLDER

DATE _____ DAY MONTH YEAR

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL