Riverview DENTAL CARE

(Please fill out both sides)

Confidential Patient Information

Patient Name: _____ ☐ Male ☐ Female
Last First MI

☐ Married ☐ Single ☐ Child ☐ Other _____ Birth Date: (DAY / MONTH / YEAR) _____

Name of Spouse_____ Names of Children _____

Phone (Home): _____(Work): _____ (Mobile):_____

Email_____

How do you prefer we contact you? ☐ Phone ☐ Text ☐ Email

Address: _____
Street Apartment #

_____
City Province Postal Code

Health Information

Name of Previous Dentist:_____Date of Last Dental Visit: _____Reason for today's visit:_____

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

☐ AIDS / HIV
☐ Allergies _____
_____
_____
☐ Anemia
☐ Arthritis/ Rheumatism
☐ Artificial Joints
☐ Asthma
☐ Autism
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Migraine Headaches
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sensory Disorder
☐ Sinus Problems
☐ Smoking
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
Please list your Medications:
_____
_____
_____
_____
_____
_____
_____

- Have you ever had any complications following dental treatment? ☐ No ☐ Yes, please explain: _____
- Have been to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes, please explain: _____
- Are you now under the care of a physician? ☐ No ☐ Yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? :_____

Is there anything else you would like to add to help us make your visits more comfortable?

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, _____
☐ Shopping in Plaza ☐ Google ☐ Recipe Card ☐ Road Sign ☐ Internet
☐ Other: _____

Special Concerns:

Are you nervous about dental treatment? ☐ no ☐ yes _____
Would you like more information on tooth whitening? ☐ no ☐ yes _____
Would you like more information on braces? ☐ no ☐ yes _____
Do you find yourself grinding your teeth at night? ☐ no ☐ yes _____
Do you require a sports mouth guard? ☐ no ☐ yes _____

If <u>someone else</u> is responsible for your account please fill out this box,

Name of Person Responsible for Account: _____
☐ Male ☐ Female
Birth Date: _____ ☐ Married ☐ Single ☐ Child ☐ Other _____
Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____
Address: _____
Street Apartment #
_____
City Province Postal Code

Insurance Holder's Information

Primary Insurance Plan

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Address: (<u>if different</u> from patient's Address)
_____
Street City Province Postal Code
Insured's Employer Name: _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name:_____

Secondary Insurance Plan

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #:_____
Insured's Address: (<u>if different</u> from patient's Address)
_____
Street City Province Postal Code
Insured's Employer Name: _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____
Insurance Plan Name:_____

Please initial all applicable items:

___ I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.

___ I hereby assign my benefits payable from claims submitted electronically or by mail to Dr. O. Rohn, Dr. S. Family, Dr. M. Hwang or Dr. K. Chen and authorize payment directly to him/her.

___ 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.

Financial Policies

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility. A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. All estimates for care are approximate.

PIPEDA

____ I acknowledge that I have been shown the office privacy policy and I understand that any information collected about me will be used only for the purposes for which it was collected and will never be shared with a third party without my consent.

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

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

_____
Printed Name of patient, parent, guardian, or guarantor of payments