BLATT
FAMILY DENTISTRY

Reviewed by DDS _____

PATIENT INFORMATION

Patient Name: _____ Today's Date: _____
Date of Birth: _____Age: _____ Gender: _____ H.C #:_____
Address:_____ City: _____Postal Code: _____
Contact info: Home: _____Cell: _____ Work: _____Email: _____
☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Common Law
Employer: _____Occupation: _____Work phone: _____
Business address:_____ City:_____ Province: _____Postal code:_____
If patient is a student, name of school/college_____ Student ID:_____
Mother/Father Name(if patient a minor) _____
To whom shall statements be sent, if other than patient:? _____ Email:_____
Person to contact in case of an emergency: _____Relationship:_____
I consent to receiving electronic communication for Blatt Family Dentistry, such as appointment confirmations, and special offers. I can opt out of this any time. Initials:_____

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient ☐friend ☐other _____
Name of person or office referring you to our practice_____

Responsible party information:

Name:_____ Email Address: _____Relation _____
Address:(if different from above):_____City: _____ Postal Code: _____
Contact info: Home: _____Cell: _____ Work: _____ Email: _____

Dental Insurance information

Primary Dental Insurance
Name of Insured: _____
Insured's Birth Date: _____
Dental Group#: _____ Member ID or certificate # _____
Employer: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____
Name of insurance plan carrier: _____

Secondary Dental Insurance
Name of Insured: _____
Insured's Birth Date: _____
Dental Group#: _____ Member ID or certificate # _____
Employer: _____
Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____
Name of insurance plan carrier: _____

Appointment Cancellations

Cancellation Charges: I understand that when an appointment is booked for me, the staff time is reserved for me. If I need to change or cancel an appointment, I will provide 2-business day's notice. I understand that without 2- business day's notice, a charge may be applied.

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DENTAL HISTORY & CONCERNS:

Reason for today's visit: _____

Former Dentist: _____Address: _____

Date of last visit: _____ Date of last x-rays: _____Date of last Hygiene: _____

How often do you floss, and brush? _____

Check if you have any of the following:

☐ Bad taste or odour in your mouth ☐ Bleeding gums when brushing ☐ Jaw popping/clicking

☐ Sensitivity to hot/cold ☐ Sore when chewing

☐ Do you want whiter teeth? ☐Sensitive to hot/cold

Do you have any other dental oral health goals you want to discuss with us? _____

MEDICAL HISTORY

Family physician's name and phone #: _____

Date of last visit: _____

Have you had any serious illness or operation? ☐ Yes ☐No

If yes, describe_____

Have you ever had a blood transfusion? ☐Yes ☐ No

If yes, give approximate dates_____

Woman: Are you pregnant? ☐Yes ☐No Due Date: _____ Nursing? ☐Yes ☐No Birth control ☐Yes ☐No

Check if you have had any of the following:

☐AIDS/HIV

☐Allergic to:_____

☐Anemia

☐Arthritis

☐ Artificial Joints

☐ Asthma

☐ Blood Disorder:_____

☐ Cancer

☐ Circulation problems

☐ Diabetes:_____

☐ Epilepsy

☐ Head Injuries

☐ Heart Disease

☐ Heart Murmur

☐ Heart Rhythm disorder

☐ Heart Surgery

☐ Hepatitis A B C _____

☐ High Cholesterol

☐ Blood Pressure ☐ High ☐ Low

☐ Kidney Disease

☐ Liver Disease

☐ Lung Disease

☐ Pacemaker

☐ Radiation Treatment

☐ Sinus problems

☐ Stroke

☐ Thyroid Disorder

☐ Tuberculosis

☐ Venereal Disease

☐ Ulcers

Other_____Medications:_____

I certify that I have read and answered the above questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Patient Signature:_____ DDS Signature:_____ Date:_____

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Patient Policy Agreement

1. Our fee are based on the current year Fee schedule of the Ontario Dental Association.

2. For your convenience, we do accept all major credit cards.

3. We would be happy to complete insurance forms related to your dental treatment. Please be aware that it is important to check the terms of your individual insurance policy carefully as coverage can vary greatly between plans. We are more than happy to provide you with any assistance regarding the coverage provided by your insurance company. You will be responsible for any fees not covered by your insurance plan.

4. The goal of our practice is that you attain the highest level of dental health possible for you. Part of your contribution to achieving your optimum dental health is making and keeping regularly scheduled appointments. The appointments are made to fit into your schedule as well as ours.

Appointments are reserved exclusively for you alone, we require 2-business day's notice for changes or cancellations of appointments or you may be charged for the missed appointment.

_____

Patient's Signature

_____

Date