ELLICE DENTAL GROUP

606 Ellice Ave, Winnipeg, MB R3G 0A3
Ph: (204) 774-3527 Fax: (204) 783-9057

GENERAL INFORMATION

NAME: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. _____ (Last Name / First Name / Initial) ☐ Male ☐ Female

BIRTHDATE: _____ (Day / Month / Year) ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

HOME ADDRESS: _____ (Apt No. / Street No. and Name)

_____ (City) _____ (Province) _____ (Postal Code) E-MAIL ADDRESS: _____

HOME PHONE NO.: (_____)_____ MOBILE PHONE NO.: (_____)_____

EMPLOYER: _____ WORK PHONE NO.: (_____)_____

* FOR CHILDREN, NAME OF PARENT(S): _____

WHOM MAY WE THANK FOR REFFERING YOU? _____

INSURANCE INFORMATION

PRIMARY SUBSCRIBER	SECONDARY SUBSCRIBER
NAME: _____	NAME: _____
DOB (dd/mm/yy): _____ /_____ /_____	DOB (dd/mm/yy): _____ /_____ /_____
EMPLOYER: _____	EMPLOYER: _____
INSURANCE COMPANY: _____	INSURANCE COMPANY: _____
GROUP#: _____ ID #: _____	GROUP#: _____ ID #: _____

CONSENT FOR SERVICES

As a condition of treatment by this office, financial arrangements must be agreed upon in advance. Any emergency dental services or arrangements may be paid in full by Visa, MasterCard, Interac, or cash at the time the services are performed. It is the policy of the office that patients are responsible for full payment of their accounts at the completion of each dental appointment.

Patients who carry dental insurance understand that all dental services are charged directly to the insurance company and that he or she is personally responsible for full payments of all dental services that are not covered. Our office will help prepare the patient's insurance forms and will assist in collecting payments from insurance companies. A service charge of 2% per month (24% per annum) on any unpaid balances will be charged on all accounts exceeding 60 days.

I consent to the performing of dental and/or oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated. I will assume responsibility for the full fees associated with those procedures.

I grant my permission to contact me at my home or work to discuss any dental or financial matters.

A missed appointment fee will be charged if appointments are cancelled or rescheduled with less than 48 hours notice.

I have read the above conditions, and agree to their content.

PATIENT'S (OR GUARDIAN'S) SIGNATURE: _____ **DATE:** _____

PATIENT'S NAME: _____

DENTAL QUESTIONNAIRE

What is the main reason for your visit today? _____

What are your chief dental concerns? _____

How do you feel about the overall appearance of your teeth? _____

Please summarize your home dental care routine: _____

When was your last visit to the dentist? _____ What was done at that time? _____

MEDICAL HISTORY

Physician's name: _____ Physician's phone number: (_____)_____

Are you presently under the care of your physician? ☐ Yes ☐ No Reason: _____

Are you presently taking any prescription or non-prescription medication? ☐ Yes ☐ No

Please list medications and dosages: _____

_____

Do you have any drug or medical allergies (e.g. antibiotics, anesthetic, etc.)? ☐ Yes ☐ No

Please list allergies: _____

Have you ever had an allergic reaction to latex? ☐ Yes ☐ No

Have you ever taken long-term cortisone or steroids? ☐ Yes ☐ No

Have you ever undergone any surgery or been hospitalized for any major illness? ☐ Yes ☐ No

Please specify: _____

Do you have any abnormal bleeding problems? ☐ Yes ☐ No

Have you ever had to take antibiotic pre-medication before a dental appointment? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How much? _____ (For Women) Are you pregnant? ☐ Yes ☐ No

Do you have or have you ever had any of the following? (please check appropriate boxes)

☐ heart trouble or stroke	☐ seizures / epilepsy	☐ kidney disease
☐ high blood pressure	☐ thyroid problems	☐ liver disease (e.g. jaundice)
☐ chest pain (angina)	☐ diabetes	☐ hepatitis
☐ rheumatic fever / heart murmur	☐ blood disorders (e.g. anemia)	☐ HIV / AIDS
☐ artificial joints / heart valves	☐ joint disorders (e.g. arthritis)	☐ sexually transmitted disease
☐ pacemaker	☐ muscle disorders	☐ tuberculosis
☐ difficulty breathing	☐ bone disorders	☐ cancer
☐ asthma	☐ digestive problems	☐ radiation therapy
☐ nervous problems	☐ ulcers	☐ fainting spells

I, the undersigned, have reviewed the information on this questionnaire, and confirm that it is accurate to the best of my knowledge.

PATIENT'S (OR GUARDIAN'S) SIGNATURE: _____ **DATE:** _____