**ACE DENTAL**

**WELCOME TO OUR PRACTICE**

In order to help us provide you with the best dental experience, please complete the following information.

**PATIENT INFORMATION:**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Day: \_\_\_\_\_\_\_\_\_\_ Month: \_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you prefer to be contacted:** (circle preferred) EMAIL**, HOME #, CELL#**

**How did you find out about our office: (internet search, sign, ad, referred by other patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If referred by other patient, please indicate patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE INFORMATION:**

**\*\*\*\*\* Please note that every Insurance Policy is different and benefit booklets are guidelines only as per the insurance companies. It is the responsibility of the policy holder and patient to know your policy coverage. It is not the responsibility of the dental office.\*\*\*\*\*\*\*\*\***

We will be photocopying your Insurance plan’s card but if you are not the primary policy holder of the Insurance plan please give the following information.

Policy holders name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan name of Insurance (this is usually name of primary plan member’s place of employment):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**:

***CIRCLE YOUR ANSWERS (leave blank if you are unsure)***

How long since your last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit? EMERGENCY EXAM OTHER

How frequently do you see a dentist? 3-6 MONTHS ANUALLY OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any of the following?

Bleeding gums YES NO Bad breath or sour taste in mouth YES NO

Soreness in jaw YES NO Burning sensation in mouth YES NO

Difficulty opening wide YES NO Clicking or popping of jaw YES NO

Sensitivity to hot/cold YES NO Food Catching between teeth YES NO

Snoring YES NO Head or mouth injury YES NO

Have you ever had local anesthetic (freezing)? YES NO

Any complications to the local anesthetic (freezing) YES NO if yes please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had problems with previous dental treatments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does having dental treatment make you nervous or afraid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your teeth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

***Circle your answers (leave blank if you are unsure)***

Are you in good health: YES NO Has there been a change in your health in last year: YES NO

If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been hospitalized or had serious illness in last 5 years: YES NO

If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently being treated by a physician: YES NO

Are you taking any drugs or medication at this time: YES NO

Name of drugs being taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE LIST ALL ALLERGIES (INCLUDE ANY DRUG OR MEDICATION ALLERGIES) :** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever experienced any of the following?**

Chest pain YES NO Seizures YES NO

Shortness of breath YES NO Bleeding problems YES NO

Persistent Cough YES NO Dry Mouth YES NO

Undiagnosed skin rash YES NO Jaundice YES NO

Sinus problems YES NO Joint pain / stiffness YES NO

Difficulty swallowing YES NO Sleep apnea or chronic snoring YES NO

Frequent vomiting, nausea YES NO Blurred vision YES NO

Dizziness YES NO Frequent headaches YES NO

Ringing in ears YES NO

**Do you have or have ever had:**

Heart disease YES NO Stroke, hardening of the arteries YES NO

Heart attack YES NO HIV Positive or AIDS YES NO

Heart murmur YES NO Anemia YES NO

Rheumatic fever YES NO VD (syphilis or gonorrhea) YES NO

High / low blood pressure YES NO Herpes YES NO

TB, emphysema YES NO Kidney / Bladder disease YES NO

Hepatitis A B C YES NO Thyroid / Adrenal disease YES NO

Ulcers YES NO Tumors, Cancer YES NO

Diabetes YES NO Eye Disease YES NO

Arthritis YES NO Family history of Heart problems YES NO

Mental / nervous disorder YES NO Diabetes or cancer YES NO

Epilepsy YES NO Lung disease YES NO

**Do you have or have you ever had any of following? (If yes please explain)**

Surgeries \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO Chemotherapy YES NO

Artificial joints YES NO Radiation Treatment YES NO

Pacemaker YES NO

**Women Only:**

Take Birth Control YES NO

Pregnant or Nursing YES NO

Planning on becoming pregnant or any possibility of becoming pregnant YES NO

**Children Only:**

Have you recently had any of the following?

Chicken pox YES NO Measles YES NO

Strep Throat YES NO Tonsillitis YES NO

Mumps YES NO

**Do you take or have you ever taken:**

Tobacco in any form YES NO Recreation Drugs YES NO

\*\* Do you have or have you ever had any other diseases or medical conditions not listed on this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Have you ever been told by a physician or dentist that you need pre-medication prior to any dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General Release:**

**I understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent please sign for children.

**Financial Policies for Direct Billing**

(Disregard if you do not have dental benefits)

Your dental Insurance is an agreement between you and your insurance company. Under no circumstance is it customary for an insurance company to cover all the fees charged. Payment of any charges insurance does not pay is your responsibility.

***We need to have a credit card on file if you have dental insurance for unforeseen balances. If you do not have a credit card then you do have to pay the full amount upfront and the Insurance will send you a cheque for what they cover.***

Direct billing to your insurance company is a courtesy to our patients and to keep being able to direct bill we must have credit card on file. ***Ace Dental does not accept any responsibility for any uncovered amounts, amounts over benefit maximum, plan limitations etc. Please be advised you should know and be aware of what your plan covers.***

If we do not receive confirmation from your insurance for their exact payment we will either estimate your portion based on insurance coverage or call you when get payment and you can have us put on credit card. If we leave a message regarding balance we will give you 4-5 days to call back if do not want on credit card, if you do not call we will automatically put on credit card on date given on message.

If your credit card information changes please advise us immediately to prevent being declined.

Credit card # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ expiry date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign even if no credit card #, stating you understand the above.

**Appointments and Cancellations Policy and Waiver**

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.

**There is a charge for not showing up for scheduled appointments*. Repeated cancellations or missed appointments will result in loss of future appointment privileges. This $50 charge will either be added to your next appointment (insurance does not pay for this) or charged to your credit card that we have on file.***

We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit.

Thank you for your cooperation.

Please sign that you have read and understood the above.

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ read and understood Ace Dental’s policy and agree to all the terms written within.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_