Welcome to our office. In order to become better acquainted and provide you with the highest standard of care, please complete the following questionnaire. All information is strictly confidential and will remain in this office.

Patient's Name ______________________ Dr.___ Mr.___ Mrs.___ Ms.___ Miss___

Preferred to be called ______________________ Date of Birth ______________________ (day/month/year)

Address: ______________________ Home Phone: ______________________

City/Province: ______________________ Work Phone: ______________ ext________

Postal Code: ______________________ Cell Phone: ______________________

Email: ______________________

May we call you at work? YES NO

How did you find out about our practice? Friend/Relative ______________________ Advertising

Family physician ______________________ Phone ______________________

In case of an emergency, please contact: ______________________ Phone ______________________

DENTAL INSURANCE

Primary Insurance		Secondary Insurance	
Subscriber's Name	______________	Subscriber's Name	______________
Date of Birth	______________	Date of Birth	______________
Insurance Company	______________	Insurance Company	______________
Group Number	______________	Group Number	______________
Certificate Number	______________	Certificate Number	______________

Insurance Information

A dental insurance policy is a contract between the insured and the insurance company. Our office, will bill your insurance company directly on your behalf for all professional services rendered. If there is a portion of the fee that is not covered by your insurance, it will be your responsibility to pay the balance on the day services are rendered. If you need to make financial arrangements please speak to our receptionist. In order to assist us in faster payments we would like to have you sign the following so we may send your claim forms electronically.

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Mary Ann Kuharchuk or Dr. Jason Nijjer and authorize payment directly to her/him.

______________________ (signature of subscriber)

I authorize release, to my dental benefits administrator, information contained in claims submitted electronically.

______________________ (signature of subscriber)

PPB Enterprises Inc. 1-877-480-2284 Form #957

DENTAL HISTORY

Please complete the following questions by answering YES/NO.

	YES	NO	
1.	☐	☐	Have you been seeing a dentist regularly? Date of your last dental visit? ______________
2.	☐	☐	Have you ever been given oral hygiene instruction in brushing and flossing?
3.	☐	☐	Have you ever had local anaesthetic?
		a)	any complication? ______________
4.	☐	☐	Are any of your teeth sensitive to:
	☐	☐	cold
	☐	☐	sweets
	☐	☐	heat
	☐	☐	pressure OTHER ______________
5.	☐	☐	Do your gums bleed? When ______________
6.	☐	☐	Do your gums feel swollen or tender?
7.	☐	☐	Do you catch food between your teeth?
8.	☐	☐	Are you aware of any loose teeth?
9.	☐	☐	Do you object to dental x-rays?
10.			Have you ever experienced any of the following jaw problems?
	☐	☐	popping / clicking in your jaw joints
	☐	☐	difficulty in opening or closing
	☐	☐	pain or difficulty while chewing
	☐	☐	pain in your jaw joints, around your ears, or side of your face
	☐	☐	pain while teeth are in a clenched position
11.	☐	☐	Do you clench or grind your teeth?
12.	☐	☐	Do you have concerns about halitosis (bad breath)?
13.	☐	☐	If you could, would you change anything about your smile? What would you like to have changed? ______
14.	☐	☐	Have you ever had a difficult experience while having dental treatment? If so, is there anything we can do to help make your visit easier? ______________

OFFICE POLICY

Appointments

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment this time is reserved for you; therefore, at least **48 hours** notice is appreciated if cancellation is absolutely necessary. A fee may also be charged.

Payment of Fees

1. Our office is willing to accept direct payment from your dental plan for services which your plan covers.
2. If your plan does not cover the full cost of your dental treatment, you will be responsible for the difference; that is the amount not paid for by your insurance plan.
3. Your portion is then due and payable on the day the service is provided by us unless other financial arrangements have been previously made.
4. You are responsible for providing the necessary information in order for us to direct bill your insurance company as well as informing us of any changes in this information.
5. If you do not have dental insurance, we are willing to make financial arrangements. Please speak to the receptionist or practice administrator.
6. At all times, an estimate is available upon your request.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information.

Consent

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic, or oral sedation as indicated. I fully understand the office policy and I will assume responsibility for fees associated with those procedures performed.

I also consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependents dental care.

Patient's (Parent's) Signature______________________________

Date ______________________

MEDICAL HISTORY

The following information is required to assist thorough diagnosis and to give the highest possible standard of professional service. All information will be strictly confidential. Please answer the following questions by answering yes/no.

YES NO

1. ☐ ☐ Are you now under the care of a physician (or have been in the last 6 months)? If so, what is the condition being treated?____

   ____

2. ☐ ☐ Have you had a serious illness or operation in the last 2 years? Please explain. ____________________

   ____

3. ☐ ☐ Are you taking any drugs or medicine including non prescription drugs? Please specify.

   A) Drug __________________________ Reason__________________________

   B) Drug __________________________ Reason__________________________

   C) Drug __________________________ Reason__________________________

   D) Drug __________________________ Reason__________________________

   E) Drug __________________________ Reason__________________________

4. ☐ ☐ Do you have a prosthetic or artificial joint?

5. ☐ ☐ Are you allergic to or have you had reactions to (please circle).

   a) local anaesthetics
   b) penicillin or other antibiotics
   c) sulfa drugs
   d) barbiturates, sedatives, or sleeping pills
   e) aspirin
   f) iodine
   g) any metals (e.g. nickel, mercury, etc.)
   h) latex
   i) other including foods (please list) ____________________________________

6. ☐ ☐ Have you ever had any excessive bleeding requiring any special treatment?

7. ☐ ☐ When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are tired?

8. ☐ ☐ Have you lost or gained more than 10 pounds in the past year?

9. ☐ ☐ Women - Are you pregnant? When is your due date?________________________

10. Please check any of the following which you have had or have at present.

- ☐ Heart Disease or Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Congenital Heart Defects
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Anemia
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Dialysis
- ☐ Ulcers
- ☐ Headaches
- ☐ Brain Injury
- ☐ Emphysema
- ☐ Lung or Breathing Problems
- ☐ Tobacco Use
- ☐ Tuberculosis (TB)
- ☐ Wheelchair dependent
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ X-ray or Cobalt Treatment
- ☐ Chemotherapy
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Cortisone / Steroid Medicine
- ☐ Glaucoma
- ☐ Pain in Jaw Joints
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Blood Transfusion
- ☐ HIV
- ☐ Drug Addiction
- ☐ Alcohol Abuse
- ☐ Hemophilia
- ☐ Venereal Disease (Syphilis, Gonorrhea)
- ☐ Cold Sores
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervousness
- ☐ Psychiatric Treatment
- ☐ Bruise Easily
- ☐ AIDS or AIDS-Related Complex