SUTTON WEST DENTAL

Thank you for selecting our dental practice.
We strive to provide you with the best possible dental care.

PATIENT INFORMATION (CONFIDENTIAL)

Patients Name: _____

Preferred Name: _____

Gender: M ☐ F ☐

Date of Birth: M ____ D _____ Y_____ Age: _____

Check appropriate Box: Minor ☐ Single ☐ Married ☐
Divorced ☐ Widowed ☐ Separated

Address: _____

City: _____

Province: _____ Postal Code: _____

Home Phone: (___)_____ Cell Phone: (___)_____

E-mail Address: _____

Health Card Number: _____

Employer/Occupation: _____

Business phone: (____)_____

Spouse or Parent/Guardian's Name: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency? _____

Phone: (___)_____

Person Responsible for this account: _____

Relationship to patient: _____

Date of birth: M _____ D _____Y_____

Phone: (___)_____

Family Physician: _____

Phone: (___)_____

INSURANCE INFORMATION

Do you have dental insurance coverage? If so, please check all that applies:

Primary Coverage ☐ Secondary Coverage ☐

Primary Insurance:

Name of Insured: _____

Date of Birth: M ____ D _____ Y _____

Relationship to Patient: _____

Insurance Company: _____

Policy Plan No. _____

Certificate/Employer's ID No. _____

Maximum Coverage: _____

How much is your deductible: _____

Used to date: _____

Secondary Insurance:

Name of Insured: _____

Date of Birth: M _____ D _____ Y _____

Relationship to Patient: _____

Insurance Company: _____

Policy Plan No. _____

Certificate/Employer's ID No. _____

Maximum Coverage: _____

How much is your deductible: _____

Used to date: _____

Medical History:

2. Date of last visit to your physician: M ___ D ___Y ____ For what purpose: _____

3. Generally, are you in good health? Yes ☐ No ☐ If no, please explain: _____

4. Are you being treated for any medical conditions at the present time, or have you been treated within the past year? If so, why?_____ Yes ☐ No ☐

5. Are you taking any prescription drugs, over the counter medications or herbal remedies? _____ Yes ☐ No ☐

If yes, please list: _____

6. Have your ever had a serious illness or been hospitalized? _____ Yes ☐ No ☐

7. Do you have or have ever had any heart or blood pressure problems? _____ Yes ☐ No ☐

8. Have you ever had any heart infection (infective endocarditic) heart valve repair or replacement congenital heart disease (from birth)? _____ Yes ☐ No ☐

9. Do you have a prosthetic or artificial joint? _____ Yes ☐ No ☐

10. Do you have any conditions or therapies that could affect your immune system? (i.e AIDS, HIV, Radiotherapy, Chemotherapy?) _____ Yes ☐ No ☐

11. Have you ever had hepatitis, Jaundice or Liver disease? _____ Yes ☐ No ☐

12. Do your bruise easily or have prolonged bleeding? _____ Yes ☐ No ☐

13. Do you have or have ever had asthma? Bronchitis? Pneumonia? (If yes please circle which) ____ Yes ☐ No ☐

14. Have you ever fainted, had shortness of breath or chest pain? _____ Yes ☐ No ☐

15. Have you ever taken Fosamax, Actonel or any other medications containing bisphosphonates? __ Yes ☐ No ☐

16. Have you ever had an allergic reaction or adverse effect to any of the following:

Latex ☐ Codeine ☐ Penecillin ☐ Sulfonamide ☐ Sleeping pills ☐ Local anaesthetic ☐

Any other allergies: _____

17. WOMEN: Are you pregnant oe breast feeding? _____ Yes ☐ No ☐

18. Do you have or have you ever had any of the following?

Chest pain (angina) ☐	Rheumatic Fever ☐	Pacemaker ☐	Steroid therapy ☐
Stroke ☐	Heart attack ☐	Mitral valve prolapse ☐	Lung disease ☐
Diabetes ☐	Kidney disease ☐	Tuberculosis ☐	Stomach ulcers ☐
Thyroid disease ☐	Heart murmur ☐	Shortness of breath ☐	Cancer ☐
Arthritis ☐	Drug dependency ☐	Alcohol dependency ☐	Seizure (Epilepsy) ☐

19. Are there any conditions or diseases you have had not listed above? _____ Yes ☐ No ☐

If yes please list _____

20. Are there any diseases or conditions that run in your family? _____ Yes ☐ No ☐

21. Do you smoke or chew tobacco products? _____ Yes ☐ No ☐

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature _____ Date: M _____ D _____Y _____

Dentist Signature _____ Date: M _____ D _____ Y _____

Dental History:

What is your immediate dental concern? _____

How would you rate the condition of your mouth? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Are your nervous about seeing a dentist? _____ Yes ☐ No ☐

How often do you see a dentist? 3-6 months ☐ Annually ☐ Other ☐ _____

Previous Dentist _____ Phone (____) _____

When was your last dental visit? Month _____Year _____ What was done? _____

Date of your most recent x-rays? Month _____ Year _____

Are you unhappy with the appearance of your teeth? _____ Yes ☐ No ☐

If yes, what would you like to change? _____

How often do your brush per day? _____ Floss _____ Mouth rinse _____

Have your been advised to take antibiotics before dental appointments? _____ Yes ☐ No ☐

Have your ever had trouble getting numb or had any reactions to local anaesthetic? _____ Yes ☐ No ☐

Have you ever experienced any of the following jaw problems:

Clicking/popping ☐ Pain ☐ Difficulty opening or closing ☐

Do you grind or clench your teeth while awake or asleep? _____ Yes ☐ No ☐

Do you have or have you had any of the following? (Please check if applicable)

Teeth sensitivity (hot/cold) ☐	Bleeding gum while brushing/flossing ☐	Orthodontic treatment ☐
Loose/shifted teeth ☐	Periodontal (gum) treatment ☐	Bad breath ☐

Please list anything else not mentioned above regarding your past dental history: _____

_____

Patient/Parent/Guardian Signature _____ Date: M _____ D _____Y _____

Patient Consent

I have reviewed the information in Form A that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Dr. Megan Ghorbanpour can collect, use and disclose personal information about _____ as set out in Form A in the information about the office's privacy policies.

Patient's name

Signature: _____ Print Name: _____

Date: _____ Signature of witness: _____

Insurance Policy

I authorize SuttonWest Dental, to submit claims to and receive payment directly from my dental insurance provider(s) for treatment rendered to me (and/or members of my family).

As a courtesy SuttonWest Dental will do a complimentary insurance benefit check for our patients. However, ultimately it is the patient's responsibility for detained information and/or all the account balances incurred from services rendered.

SuttonWest Dental does not bill services according to patient's supported benefits, we bill according to services required on an individual as-needed basis. If in doubt of insurance support, we send for predeterminations. However, even when we receive approval for a service, in between the time we bill and receive payment the insurance carrier could change a policy without notice rendering the approval invalid.

When changes in policies, carriers, and termination of plans occur, insurance companies do not inform dental offices. It is the patient's responsibility to know and advise us when these changes occur and again are ultimately responsible for any balances that are incurred from services rendered, as a result of the above.

Even though we have extensive knowledge with insurance carriers, it is to your benefit to read your employee handbook and understand your covered services. Ultimately, it is a contract between you and your employer. We encourage you to talk to your insurance carrier regarding the coverage details of your plan. This will avoid any disappointment regarding changes and or the decline in payment of services.

In some cases, insurance carriers only correspond with their members; in this case your need to inform SuttonWest Dental so that we can assist you in understanding these correspondences.

As a patient of SuttonWest Dental, I have read and understand the above insurance policy. Any treatment that my insurance does not pay or exceeds the limits of my plan will be my responsibility and billed directly to me.

I understand in authorizing SuttonWest Dental to render treatment, I am responsible for and agree to pay SuttonWest Dental any outstanding amount that is not paid to SuttonWest Dental, for whatever reason, by my dental insurance provider(s). I agree to pay SuttonWest Dental any outstanding amount within 30 days of such account being rendered to me.

Patient/Parent/Guardian Signature _____ Date: M _____ D _____Y _____