1 PERSONAL INFORMATION (Please Print)

DATE ____/____/____ (D M Y)

Name: Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐ Dr. ☐ _____ (FIRST NAME) _____ (LAST NAME)

Address: _____ (NUMBER) _____ (STREET) _____ (APT)

_____ (CITY) _____ (PROV) _____ (POSTAL CODE) Place of Birth _____

Date of Birth ____/____/____ (D M Y) Height _____ Weight _____

Telephone: Residence _____ Business _____ Ext. _____

Email _____ Referred by: _____

Occupation: _____ Place of Business: _____

Primary Dental Insurance Company: _____

Group No. _____ ID No. _____

Secondary Dental Insurance Company: _____

Group No. _____ ID No. _____

Secondary Policy Holder: _____ Date of Birth: ____/____/____ (D M Y)

Physician: Name & address: _____ Telephone _____

In case of emergency please notify: Name _____

Relationship _____ Telephone _____

2. MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

1. Are you presently under the care of a physician? ..... YES ☐ NO ☐
2. Have you ever been hospitalized? ..... YES ☐ NO ☐
   Specify: _____
3. Do you have a heart or circulatory problem of any kind? ..... YES ☐ NO ☐
   Specify: _____
4. Have you ever had rheumatic fever? ..... YES ☐ NO ☐
5. Do you have any allergies? ..... YES ☐ NO ☐
   Specify: _____
6. Are you presently taking any kind of medication? ..... YES ☐ NO ☐
   Specify: A) Drug _____ Reason _____
   B) Drug _____ Reason _____
   C) Drug _____ Reason _____
7. Do you have or have you ever had a bleeding problem? ..... YES ☐ NO ☐
8. Are you pregnant? ..... YES ☐ NO ☐
9. Have you ever had a reaction to any kind of medication? ..... YES ☐ NO ☐
   Specify: _____
10. Do you presently or have you ever had:

Anaemia ☐	Hemorrhage ☐	Rheumatism ☐
Arthritis ☐	High (Low) blood pressure ☐	Scarlet fever ☐
Asthma ☐	Hyper (Hypo) glycemia ☐	Stomach (Intestinal) Ulcer ☐
Blood disorder ☐	Kidney disease ☐	Stroke ☐
Cancer ☐	Liver disease (e.g. Hepatitis) ☐	Thyroid problem ☐
Diabetes ☐	Lung disease ☐	Tuberculosis ☐
Epilepsy ☐	Mental or nervous disorder ☐	Venereal disease ☐
Hay Fever ☐	Migraine headaches ☐	HIV ☐

11. Have you ever had a concussion? ..... YES ☐ NO ☐
12. Have you ever fainted? ..... YES ☐ NO ☐
13. Have you ever had any illness not included above? ..... YES ☐ NO ☐
    Specify: _____

Medical update _____

_____

_____

_____

_____

3. DENTAL HISTORY

1. How frequently do you see your dentist?
   6 Months ☐ Yearly ☐ Other _____ Last dental visit _____
2. Have you ever been given oral hygiene instruction in:
   Brushing ☐ Flossing ☐ Other _____
3. Have you ever had local anaesthetic? ..... YES ☐ NO ☐
   Any complications _____
4. Are any of your teeth sensitive to:
   Cold ☐ Sweets ☐ Heat ☐ Other _____
5. Do your gums bleed when: Brushing ☐ Flossing ☐ Spontaneously ☐
6. Do your gums feel swollen or tender? ..... YES ☐ NO ☐
7. Do you catch food between your teeth? ..... YES ☐ NO ☐
8. Are you aware of any loose teeth? ..... YES ☐ NO ☐
9. Have you ever had a full mouth series of dental x-rays? ..... YES ☐ NO ☐
10. Does your jaw crack, pop or grate when you open widely? ..... YES ☐ NO ☐
11. Do you grind or clench your teeth? ..... YES ☐ NO ☐

Dental Update: _____

_____

_____

PATIENT CERTIFICATION AND APPROVAL

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information.

Patient (Parent, Guardian) Signature _____ Date _____

PATIENT (GUARDIAN) CONSENT (FOR MINORS)

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

Patient (Parent, Guardian) Signature _____ Date _____

Dr Glenn S. McKay

Rockwood Dental Group

22B-4141 Dixie Rd

Mississauga ON L4W 1V5

905 624 8917

Date_____

This office operates on the Current ODA fee Guide for **Most** dental procedures.

Because Insurance companies/policies change so often it is your responsibility to be aware of plan maximums and what your plan covers. We can send estimates to insurance companies for you however, We provide dental services you require not what your plan covers.

Any Balance or non payment from the insurance company is your responsibility.

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

I agree that ***Rockwood Dental Group*** can collect, use and disclose personal information to specialists and insurance companies about me/my dependant as set out in the PIPEDA.

_____ _____

Signature Print name

_____ _____

Date Signature of witness

Insurance & Payment Policy

At Rockwood dental Group, we make every effort to aid you in collecting the maximum benefit payable from your insurance company. Please review our insurance and payment policy.

Payment Options:

Our mission is to provide excellence in dentistry that meets your individual needs. **In order to reduce the cost of providing dentistry to our patients, payment is expected at the time of service.**

We are pleased to offer the following payment options:

☐ Option #1 **Non-assignment of benefits with payment in full.**

Payment is made in full by cash, interact, Visa, or MasterCard with non-assignment of your dental benefits. We will process your dental insurance claim for you and have the **insurance cheque sent directly to you** within 3-5 business days.

☐ Option #2 **Assignment of benefits secured with your credit card.**

We will accept assignment of your primary dental benefits and collect the co-payment at the time of service. We will provide you with a copy of any secondary insurance claims for you to submit. A credit card will be kept on file to process any payment not reimbursed to us within 30 days and a receipt of any charges will be mailed to you.

I hereby assign payment of my dental benefits directly to *Rockwood Dental Group*.

I hereby authorize *Rockwood Dental Group* to process payment to my credit card of any outstanding balance occurred during the course of dental treatment to keep my account current within 30 days.

Credit Card #:_____ Exp Date:____/____

Patient Name: _____

Patient Signature: _____

Date: _____