Welcome to Bowmanville DENTAL

(Please fill out both forms)

Confidential Patient Information

Patient Name: _____ Date: _____
Last First Middle Initial

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

S.I.N.# _____ Birth Date: (DAY/MONTH/YEAR) _____

Name of Spouse _____ Names of Children _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Mobile: _____ Email: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address: _____
Street Apartment #

_____
City Province Postal Code

Health Information

Name of Previous Dentist: _____ Date of last dental visit: _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

☐ Aids/HIV
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Migraine Headaches
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoking
☐ Stomach Problems
☐ Stroke
☐ Thyroid Condition
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

Please list your Medications:

_____
_____
_____
_____
_____
_____
_____

Have you ever had any complications following dental treatment? ☐ No ☐ Yes, please explain: _____

_____

Have you been to a hospital or needed emergency care during the past two years? ☐ No ☐ Yes, please explain:

_____

Are you now under the care of a physician? ☐ No ☐ Yes, please explain: _____

Name of physician: _____ Phone #: _____

Do you have any health problems that need further clarification? _____

Is there anything else you would like to add to make your visits more comfortable?

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient _____

☐ Shopping in Plaza ☐ Yellow Pages ☐ Goldbook ☐ Website ☐ Newsletter ☐ Road Sign ☐ Newspaper

☐ Television Commercial ☐ Other _____

Special Concerns

Are you nervous about dental treatment? ☐ No ☐ Yes _____

Would you like more information on tooth whitening? ☐ No ☐ Yes _____

Would you like more information on braces? ☐ No ☐ Yes _____

Are you aware of night time tooth grinding? ☐ No ☐ Yes _____

Do you require a sports mouth guard? ☐ No ☐ Yes _____

If **someone else** is responsible for your account please fill in this box.

Name of Person Responsible for Account: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

S.I.N.#: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City Province Postal Code

Insurance Holder's Information

Primary Insurance Plans

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First Middle Initial

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: (if **different** from patients address)

_____
Street City Province Postal Code

Insured's Employer Name: _____

Patients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Secondary Insurance Plans

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First Middle Initial

Insured's Birth Date: _____ ID#: _____ Group #: _____

Insured's Address: (if **different** from patients address)

_____
Street City Province Postal Code

Insured's Employer Name: _____

Patients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name: _____

Please Initial All Applicable Items:

_____ I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.

_____ I hereby assign my benefits payable from claims submitted electronically or by mail to Dr S Levy and authorize payment directly to him .

_____ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Financial Policies

- Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility.
- A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.
- All estimates for care are approximate.
- I have read the above conditions of treatment and payment and agree to their content.

_____ _____ _____
Signature of patient, parent, guardian, or guarantor of payments Date: Relationship to Patient:

_____
Printed Name of patient, parent, guardian, or guarantor of payments