BOWMANVILLE DENTAL

Patient Registration Form

Date of Visit: _____ Salutation: ☐ Mr. ☐Mrs. ☐Ms. ☐Miss/Master

First Name_____ Last Name: _____

Date of Birth:_____ Gender: ☐Male ☐Female

Address: _____ City: _____ Postal Code: _____

Home Tel: _____ Work: _____ext. _____ Cell: _____

E-mail address: _____

Best Time To Contact You: ☐ Morning ☐ Afternoon ☐ Evening Best Method: ☐ E-mail ☐Home # ☐Cell #

Emergency Contact: In case of an emergency, who should we call?

Name: _____ Relationship to you: _____

Home Tel #: _____ Work Tel #: _____ Cell #: _____

Financial Responsibility: ☐ I am over 18 years old and responsible for my account. ☐ I am under 18 years old and the following person is responsible for my account:

Name: _____ Relationship to you: _____

Address: _____ City: _____ Postal Code: _____

Tel Home: _____ Work _____ Cell: _____ E-mail: _____

Medical History: Have you ever had any of the following?

- ☐ AIDS/ HIV
- ☐ Allergic to: _____
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disorder: _____
- ☐ Cancer
- ☐ Diabetes ☐ Type I ☐ Type II
- ☐ Dizziness
- ☐ Epliepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Migraines
- ☐ Blood Pressure ☐ High ☐ Low
- ☐ Jaundice
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Nervous System Disorder
- ☐ Mental Disorder
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Smoking
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers

For Women: Are you currently Pregnant? ☐ Yes ☐No

Due Date: _____

Additional notes re: health: _____

Please list your regular medications: _____

Have you been hospitalized or required emergency medical care in the last two years? ☐ No ☐ Yes, provide details below

_____

Have you been tested for COVID-19? ☐ No ☐ Yes, Test Date: _____ What were the results? ☐ Negative ☐ Positive

Name of your physician:_____ Tel #: _____

Identification Required For Prescriptions: New regulations require us to obtain photo ID in order to write many prescriptions. We will need your Health Card information.

Photo Health Card Number: _____ Version Code: _____ Expiry Date: _____

Dental History & Concerns Mark the areas that apply, and if desired, use the lines to provide additional details.

When was your last dental visit? _____ Name of dentist: _____

What did you like about your previous dental office? _____

Anything you disliked about your previous dental office? _____

Do you need sedation to make your visits comfortable? _____

□ Do your gums bleed at all when you brush your teeth? _____

□ Do you experience a bad taste or odour in your mouth? _____

□ Are any of your teeth sensitive to hot or cold? _____

□ Are any of your teeth sore to chew on? _____

□ Does your jaw click or crack or pop? _____

□ Do you want whiter teeth? _____

□ What are your goals for your visit today? _____

Insurance Coverage

Primary Insurance

Name Of Insured:_____

□ Male □ Female Date Of Birth: _____

Employer: _____

Insurance Company:_____

Group/ Plan/ Policy #:_____

ID / Certificate #: _____

Secondary Insurance

Name Of Insured:_____

□ Male □ Female Date Of Birth: _____

Employer: _____

Insurance Company: _____

Group/ Plan/ Policy #:_____

ID / Certificate #: _____

Who Can We Thank For Your Referral?

□ A friend or □ family member named: _____

□ Google Search □Yellow Pages □ Billboard/ In mall □SNAP Clarington □Clarington This Week

□ Welcome Wagon □Live in Neighbourhood □Other_____

We will gladly accept your friends and family members in our practice. Feel free to share our contact information. Thank you!

Appointment Cancellations

I understand that when an appointment is booked for me, the time is reserved with my care provider and materials are set for me. If I need to change or cancel an appointment, I will provide 2 business days notice (unless a grave emergency occurs). I understand that without 2 business days notice, a charge may apply.
I initial to signify that I understand this policy: _____

To the best of my knowledge, all the information I have provided herein is accurate and complete. I consent to a dental examination today. I consent to basic restorative care, as recommended by the examining dentist.

_____ _____

Signature of Patient OR Guarantor Of Payments Date:

BOWMANVILLE DENTAL

Informed Consent to Advertise on our Website & Social Media Pages

First name only along with all photographs, film,video, or other audio-visual recording taken of the adult or child by Bowmanville Dental shall be and remain the sole and exclusive property of Bowmanville Dental and may be stored, maintained, used, modified, published or broadcast in any medium now known or hereafter devised, without payment or compensation by bowmanville Dental & its advertising and promotional agencies.

ACKNOWLEDGEMENT

I/We have read the above, and I/We understand.

Signature of Patient/Parent/Guardian: _____Date: _____

BOWMANVILLE DENTAL

Insurance & Payment Agreement

Our mission at Bowmanville Dental is to provide excellence in dentistry that meets your individual needs.

As your dental health care providers, our job is to **assess your oral condition and advise you of** the health of your mouth or of any decay, infections, tissue damage, bone loss or other conditions you may have.

Just like any other doctor, we are obligated to treat all patients the same. ***We advise you of treatment options based on your condition, regardless of whether or not you have insurance or what it may or may not cover.*** Insurance plans are ***not*** designed to meet individual treatment needs. You can choose to proceed or decline treatment. If you have the benefit of some insurance coverage, it is **your responsibility to know what is and isn't covered**. We will gladly submit an estimate to your insurance for you.

There are over 65,000 different plans in Ontario alone. We do not know what yours covers.

Just like the grocery store, your auto service business, your hairdresser or barber etc, **payment is expected on the day of your appointment.** Please choose your preferred method of payment:

☐ **Option #1 Payment in full on day of appointment. Benefit from insurance company paid directly to you**

Payment is made in full by cash, interact, Visa, or MasterCard by the patient or guardian for the patient. We will process your dental insurance claim for you. Any **insurance benefit payment owing is sent directly to you**, usually between 1-5 business days. Patients choose this method to avoid any balance from ever accruing on their account, and to keep their account simple and easy to understand.

☐ **Option #2** **Insurance pays Bowmanville Dental directly + patient or guardian pays their portion directly. To choose this option, a credit card is required, on file.**

We will accept payment directly from your insurance company if your insurance allows for it, and:

- Your portion is paid on the day of your visit (or as soon as your ins. company indicates what the portion is)
- A valid credit card is kept on file, to which your payment will be billed if you either 1) authorize it or 2) can't make it in to the office to make your payment within 30 days

To choose this option, provide a credit card number & sign below:

I hereby agree to assign payment of my dental benefits directly to Bowmanville Dental. I hereby authorize Bowmanville Dental to charge my credit card below, for any balance 31 days past due.

CREDIT CARD NUMBER:_____ EXPIRY:____/____

NAME ON CARD:_____ CSV:____

Patient Name: _____

Patient Signature: _____Date: _____