Franklin Dental Centre

Thank you for choosing Franklin Dental Centre and for giving us the opportunity to provide you with outstanding dental care. Please let us know if there is anything we can do to make today's visit more comfortable for you.

INFORMATION YOU GIVE US IS STRICTLY CONFIDENTIAL AND WILL NOT BE RELEASED TO ANYONE WITHOUT YOUR WRITTEN PERMISSION.
TO HELP US PROVIDE YOU WITH THE BEST DENTAL CARE POSSIBLE, PLEASE PROVIDE US WITH COMPLETE INFORMATION AND DON'T SKIP ANY QUESTIONS.
WE WILL REVIEW THE QUESTIONNAIRE AND DISCUSS IT WITH YOU IN DETAIL. IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO ASK THE DENTIST.

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ Walk-in ☐ Friend ☐ Internet Search ☐ Facebook
☐ Referred by

PATIENT INFORMATION

☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr	Date of Birth DD / MM / YYYY	Last Name	
First And Middle Names:		Preferred Name	
Home Address			
City		Province	Postal Code
☐ Home Phone	☐ Work Phone		☐ Cell Phone
Email		☐ I would like to receive notifications and appointment reminders by email	
Employer		Occupation	
IN CASE OF EMERGENCY, PLEASE NOTIFY:			
Name		Relationship to Patient	
Daytime Phone		Other Phone	
PERSON RESPONSIBLE FOR THIS ACCOUNT: ☐ Patient (if someone other than patient, please complete the section below)			
Last Name		First And Middle Names	
Relationship to Patient		Date of Birth DD / MM / YYYY	
Home Address			
City & Province		Postal Code	
☐ Home Phone	☐ Work Phone	☐ Cell Phone	
Employer		Is this person a patient at our office? ☐ YES ☐ NO	

CONSENT:

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

☐ **I consent to the collection, use or disclosure of personal information as required for my own or my dependants' dental care. I hereby authorize the taking of radiographs (x-rays), study models, photographs or any other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis of my dental needs.**

☐ **I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic as indicated and I will assume responsibility for fees associated with those procedures. I understand that the use of medications, anesthetics and some procedures embody a certain risk. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for these additional procedures is my responsibility.**

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE**_____

MEDICAL HISTORY

1. When was your last medical examination?	Purpose:
2. Have you been treated for any medical condition within the past year? ☐ YES ☐ NO	Details
3. Have you traveled outside Canada within the last year? ☐ YES ☐ NO	Destination
4. Have you had an unusual or persistent cough or rash in the past 3 weeks that has not been examined by your family doctor? ☐ YES ☐ NO	
5. Has there been any change in your general health in the past year? ☐ YES ☐ NO	Details
6. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? ☐ YES ☐ NO	Please list

7. Are you allergic to or have you had adverse reactions to any of the following? (please check all that apply):

☐ Local Anesthetics ☐ Barbiturates or Sedatives ☐ Penicillin or Other Antibiotics ☐ Aspirin ☐ Bisphosphonates (for Osteoporosis)
☐ Iodine ☐ Latex or Rubber ☐ Codeine ☐ Any metals (like Nickel, Mercury etc)
☐ Sulfa Drugs ☐ Other (please list)

8. Have you ever had a peculiar or adverse reaction to any medications or injection? ☐ YES ☐ NO	Details
9. Do you have, or have you ever had, endocarditis, a prosthetic heart valve, heart transplant or other heart surgery? ☐ YES ☐ NO	
10. Do you have a prosthetic or artificial joint? ☐ YES ☐ NO	
11. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ YES ☐ NO	
12. Do you have any conditions or therapies that could affect your immune system like leukemia, radiotherapy, chemotherapy, transplant surgery? ☐ YES ☐ NO	
13. Do you have a bleeding problem or bleeding disorder? Do you bruise easily? ☐ YES ☐ NO	
14. Have you ever been hospitalized for any serious illness or major surgery? ☐ YES ☐ NO	Details

15. Do you have or have you ever had any of the following? (Please check all that apply)

☐ heart disease	☐ hepatitis	☐ chest pain, angina	☐ shortness of breath	☐ pacemaker	☐ steroid therapy	☐ seizures(epilepsy)
☐ heart attack	☐ lung disease	☐ diabetes	☐ kidney disease	☐ tuberculosis	☐ thyroid disease	☐ swollen ankles/feet/hands
☐ stroke	☐ prosthetic heart valve	☐ stomach ulcers	☐ anxiety disorder	☐ eating disorder	☐ low blood sugar	☐ drug/alcohol dependency
☐ glaucoma	☐ cancer	☐ arthritis	☐ diet pill therapy	☐ asthma	☐ HIV/AIDS,	☐ jaundice
☐ liver disease	☐ high/low blood pressure		☐ other (please describe)			

16. Are there any disease or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ YES ☐ NO	Details
17. Do you smoke or chew tobacco products? ☐ YES ☐ NO	Details
18. *For women only*: Are you breast-feeding or pregnant? ☐ YES ☐ NO	Due Date
19. Do you have any other disease, disorder or condition not listed above? ☐ YES ☐ NO	Details

20. Please indicate your	Height ft in	Weight lbs	*OFFICE USE: BMI*

☐ **I understand the need for these questions to be answered truthfully and that providing inaccurate information can be dangerous to my health. To the best of my knowledge, the answers I have given are complete and accurate. I also understand that it is my responsibility to inform Franklin Dental Centre of any changes or updates in my medical status, including new medications.**

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE**_____

➡ **DENTIST SIGNATURE:** _____ **DATE**_____

DENTAL HISTORY

What is the reason for today's visit to our office?						
Before today, when was your last dental visit and what was done at that visit?						
Who was your previous dentist? (Name and Location)						
How often to do you schedule routine dental visits?	☐ every 3 months	☐ every 6 months	☐ every 12 months	☐ never		
How would you rate your overall oral health?	☐ excellent	☐ good	☐ fair	☐ poor		
How often do you	brush your teeth?	times a day/week	floss?	times a day/week	use mouthwash?	times a day/week
Do you have any of the following?	☐ complete denture	☐ partial denture	☐ bridge	☐ implant		
How fearful are you of dental treatment?	(extremely fearful) ☐ 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐1 (not at all)					
Have you had a unfavourable or traumatic dental experience?	☐ YES ☐ NO					
Have you ever had any difficult extractions or prolonged bleeding during dental visits?	☐ YES ☐ NO	Do you have a very sensitive gag reflex?	☐ YES ☐ NO			
Have you ever had trouble getting numb or had any adverse reaction to local anesthetic?	☐ YES ☐ NO	Do you have trouble lying flat in the dental chair?	☐ YES ☐ NO			

YOUR BITE AND JAW (Please check all that apply to you)

☐ I have noticed a clicking or popping noise in my jaw	☐ I have difficulty opening or closing my mouth
☐ I have problems chewing tough foods like bagels	☐ I have noticed shifting in the position of my teeth
☐ I have had braces or had my bite adjusted	☐ I have frequent headaches, sometimes even when waking up
☐ I find myself clenching or grinding my teeth	☐ I frequently bite my lips or cheeks
☐ I have had head, neck or jaw injuries	☐ I have worn a bite plate, mouth guard or other appliance

YOUR TOOTH STRUCTURE (Please check all that apply to you)

☐ My mouth seems dry and/or I have trouble swallowing food	☐ My teeth are sensitive to hot or cold foods or liquids
☐ My teeth are sensitive to sweet or sour foods or liquids	☐ I find that food tends to get caught between my teeth
☐ I have broken or chipped a tooth or had a cracked filling in the past	

YOUR GUMS AND BONE (Please check all that apply to you)

☐ My gums bleed when brushing or flossing	☐ I have been treated for periodontal (gum) disease
☐ Some of my teeth feel loose	☐ I have sores, bleeding, pus or lumps in or near my mouth
☐ I suffer from bad breath or an unpleasant taste in my mouth	

YOUR SMILE (Please check all that apply to you)

☐ I have whitened my teeth in the past (at home or a dental office)	☐ I am embarrassed to smile or uncomfortable about the appearance of my teeth
☐ I would like to change the appearance of my teeth	

INSURANCE INFORMATION

Do you have Insurance Coverage? ☐ YES ☐ NO	Are you claiming from more than one insurance company? ☐ YES ☐ NO
Have you used your Insurance at another office during the current coverage term? ☐ YES ☐ NO	Name of Dental Clinic
PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Patient	Name of Patient
Relationship to Policy Holder ☐ Spouse ☐ Dependant	Relationship to Policy Holder ☐ Spouse ☐ Dependant
Insurance Company	Insurance Company
Policy Number/Group #	Policy Number/Group #
Subscriber ID/Certificate #	Subscriber ID/ Certificate #
Name of Policy Holder	Name of Policy Holder
Policy Holder Date of Birth DD / MM / YYYY	Policy Holder Date of Birth DD / MM / YYYY
Employer	Employer

PAYMENT (PLEASE CHECK EACH BOX TO ACKNOWLEDGE THAT YOU ACCEPT THESE TERMS)

☐ **I understand that Franklin Dental Centre offers different forms of payment to make their services more affordable for patients and confirm that I will address any concerns regarding payment with the financial coordinator before treatment is started.**

☐ **Regardless of method of payment, I agree to unconditionally pay for services rendered, irrespective of payment by insurance carriers, workers compensation etc.**

☐ **I also agree to pay for services when they are rendered unless other arrangements have been made with the financial coordinator in advance. I understand that financial charges will be added to my account for delinquent payment. I further agree to pay for attorney's fees and collection costs in the event I fail to pay or my insurance fails to pay my account in full within 60+ days of receipt of services.**

☐ **I understand that Franklin Dental Centre will submit claims to my insurance carrier on my behalf and acknowledge that it might be necessary to resubmit a claim for any number of reasons. In the event of a resubmission, I understand that I might be required to sign a claim form and I understand that failure to sign the claim form in a timely matter will result in all outstanding charges to be transferred to me immediately without prior notice.**

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE**_____

AUTHORIZATION

☐ **I confirm that, to the best of my knowledge, the above information is correct. I authorize the release of information contained in claims submitted electronically to my dental benefits plan administrator and CDA. I also authorize the communication of information related to the coverage of services described to the named dentist.**

☐ **I hereby assign my benefits, payable from claims submitted electronically, to Dr Morris and authorize payment directly to him. The authorization shall continue in effect until the undersigned revoke the same.**

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE**_____

CANCELLATION AND NO SHOW POLICY

Our goal is to provide quality dental care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of dental care.

Definition of a No Show: Our definition of a No Show is a patient who: does not show up for their scheduled appointment, cancels or reschedules their appointment with less than 24 hours notice, or shows up more than 20 minutes late for the appointment.

No-Show Policy: If you fail to keep a scheduled appointment, we reserve the right to charge $50 for every scheduled ½ hour, to a maximum of $400.

Cancellation of an Appointment: In order to be respectful of the dental needs of other patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely dental care.

Appointment Confirmations: As a courtesy, we will attempt to remind you of your appointment by calling, emailing or texting you 1 or 2 days prior to confirm your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for you and in the event that we are unsuccessful in our efforts to confirm your appointment, it is still your responsibility to keep the appointment.

☐ **I, _____ understand that when I make an appointment, it is my responsibility to ensure that I keep the appointment, regardless of whether I receive a reminder from Franklin Dental Centre or not. I acknowledge that Franklin Dental Centre requires <u>24 hour advance notice</u> if I am unable to keep a scheduled appointment. I understand that if I fail to keep a scheduled appointment, I will be charged $50 for every scheduled ½ hour. In the event that I fail to keep a scheduled appointment without 24 hour notice, I authorize Franklin Dental Centre to charge the cancellation fee to the following Credit Card:**

Card Type ☐ VISA ☐ Mastercard	Name on Card	
Card Number	Expiry Date M M / Y Y	Security Code

➡ **CARD HOLDER SIGNATURE:** _____ **DATE**_____

➡ **PATIENT/ PARENT/GUARDIAN SIGNATURE:** _____ **DATE**_____

FOR OFFICE USE ONLY	*DATE ENTERED D D / M M / Y Y Y Y*	*INITIAL*