



# Welcome Form



E-mail:	Today's Date:
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## Personal

Name:			Home Phone:		Business:		Cell:	
Last	First	Middle	( )	( )	( )	( )	( )	( )
Address:			City:		Province:		Postal Code:	
Occupation:				Date of birth:			Sex: M F	
Emergency Contact:			Relationship:		Home Phone:		Cell Phone:	
					( )		( )	

## Insurance

Name of Primary insuring agency or plan:			Employer:			
Group Policy/Plan Number:			Certificate/ I.D. Number:		Division/Section Number:	
Name of Secondary insuring agency or plan:			Employer:			
Group Policy/Plan Number:			Certificate/ I.D. Number:		Division/Section Number:	

## Dental Information

For the following questions, please mark (X) your response. (Check DK if you Don't Know the answer)

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pain? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any sores in your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had orthodontic (braces) treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any implants? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental exam: _____			
Are you currently experiencing dental pain or discomfort? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time? _____			
				_____			
				Date of last dental x-rays: _____			

## Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following.

	Yes	No		Yes	No	DK
Are you now under the care of a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking any prescription or over the counter medicine(s)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name and Number: _____			If so, please list it all including vitamins, natural/herbal and diet supplements:			
Has there been any changes in your general health within the past year? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If so please explain: _____			_____			
Date of last physical exam: _____			Do you smoke or use any tobacco products? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a serious illness, operation or been hospitalized in the past 3 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	Women Only:			
If so please explain: _____			Are you pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____			If so how many weeks _____			



## Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following.

Allergies -Are you allergic to or have you had a reaction to:	Yes	No	DK		Yes	No	DK
Local anesthetics .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark (X) your response to indicate if you have or have not had any of the following.

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HPV .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GE reflux/heartburn .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizzy spells .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health challenges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold sores .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brain injury .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart surgery .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Celiac disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malignant hypothermia .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____			

## Patient Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

**Payment:** Payment is due at the time of service rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment. We accept the following forms of payment: cash, debit cards and credit cards.

**Dental Benefits Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan provider. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to assist our clients with dental benefit plans to understand their coverage. You are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the client's portion (deductible, co-pay or any amount not covered by the dental plan) in full at the time of service.

**Scheduling of Appointments:** We reserve the hygienist's time on the schedule for each client procedure and are diligent about being on time. Because of this courtesy, when a client cancels an appointment, it affects the overall service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of \$50.00 or deposit to reserve the appointment time again, may be required. To reschedule an appointment due to late arrival, a fee of \$50.00 may be required.

## Client Authorizations

Initial

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment

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I have read the above and agree to the financial and scheduling terms

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I authorize the release of information necessary to process my dental benefit claims and authorize payment directly to this office

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Client/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_