

Personal Information

Last Name: _____ First Name: _____ Preferred Name: _____

Date of birth: _____ (Day-Month-Year)

Address: _____

City: _____ Province: _____ Postal Code: _____

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

Email: _____ Occupation: _____

Preferred method of contact: Cell Home Email Work

I consent to receive text messages/emails from Petrolia Dentistry regarding my appointments

Physician's name: _____ Physician's Phone: _____

Health Card Number: _____ Pharmacy: _____

Whom may we thank for referring you? _____

Guardian Information / Person Responsible for Account (if different than above)

Last Name: _____ First Name: _____ Preferred Name: _____

Date of birth: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell #: _____ Work #: _____

Occupation: _____ Email: _____

In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Financial Policy and Insurance

Our policy is that full payment is due the day that treatment is performed. Our office will send your claim electronically to your insurance carrier, or provide you with a claim form if your insurance carrier does not accept claims electronically. The patient is then responsible for making sure their claim is filed. Occasionally, an exception is made where we will have the insurance payment come directly to us. Under those circumstances, the patient is responsible for paying any portion not covered by insurance (i.e. the "co-payment") on the day of the appointment. **It is the patient's responsibility to track coverage and annual benefit maximums. Please note that there will be a 2% monthly surcharge on accounts 30 days past due.** When more extensive dental treatment is required, upon request, we can send an estimate or predetermination to your insurance carrier(s). The response is usually sent directly to the patient within 2-3 weeks. Please look for it in your mail or online and notify us once you receive it so that we may book the necessary appointments to expedite your treatment.

Accepted Methods of Payment

We accept VISA, MasterCard, Debit, or Cash as methods of payments.

Cancellation Policy and Missed Appointments

Keeping in mind that our goal is to serve the needs of all patients, especially those in acute pain, patients wishing to change their appointments must provide a **minimum 48 hours notice**. The office reserves the right to charge for missed appointments and appointments cancelled with less than 48 hours of advance notice. Consistent missed appointments or short-notice cancellations may result in dismissal from our practice. Of course, exceptions will be made for illness, personal tragedy or other extenuating circumstances.

Deposits for Major Work

If dentures, crowns, or bridges are to be fabricated by a dental laboratory, and the patient does not have dental insurance, our office may request a deposit before the case is sent to the laboratory. The remaining balance will be due at the time the prosthesis delivered.

Patient Consent

GENERAL CONSENT: I consent to my physician, pharmacist, and previous dentist(s) being contacted if necessary to complete my Medical/Dental history to help ensure safe dental treatment. I also authorize Dr. Hoben & Associates to provide medical and dental records to dental specialists for the purposes of referral should the need arise. I authorize Dr. Hoben & Associates to perform diagnostic, dental and oral surgery procedures and services including the use of anesthetic as necessary. I also accept and agree to the terms of Petrolia Dentistry's Financial Policy and understand that I assume responsibility for all fees associated with these procedures and services.

Patient/Parent/Guardian Signature: _____ Date: _____

GENERAL RELEASE: I authorize release to my dental benefit plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Patient/Parent/Guardian Signature: _____ Date: _____

CONSENT TO DENTAL PHOTOGRAPHY: I authorize Dr. Hoben & Associates to take photographs of my face, jaws and teeth, before, during and after treatment for purposes of the following: dental records, dental research, dental education (lectures, seminars, demonstrations, and professional publications), and marketing material (websites and printed materials). I understand that if photographs are used, my name or other identifying information will be kept confidential.

Check here if you do NOT want your full face shot used for anything other than dental records and treatment planning

Patient/Parent/Guardian Signature: _____ Date: _____

In order to provide you with the safest treatment, please answer the following questions as accurately as possible and provide as much detail as possible. *If you are unsure of the answer, please mark DK ("don't know") beside the item.*

YES	NO	Cardiovascular	YES	NO	Renal	YES	NO	Eyes/Ears
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or tightness	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Impaired vision
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack, date: _____	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Impaired hearing
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	YES	NO	Liver	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health
<input type="checkbox"/>	<input type="checkbox"/>	Heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease or jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (non-viral)	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder
<input type="checkbox"/>	<input type="checkbox"/>	Heart infection or infective endocarditis	YES	NO	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder
<input type="checkbox"/>	<input type="checkbox"/>	Repaired or artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion/Acid reflux	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar disorder
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or implantable defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>	<input type="checkbox"/>	Dementia
<input type="checkbox"/>	<input type="checkbox"/>	Stroke, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/intestinal ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Learning disorder
YES	NO	Respiratory	YES	NO	Immune	YES	NO	Infections
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Steroid use in past 2 years	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Delayed healing	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: Type? _____
<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	Stem cell/organ transplant	<input type="checkbox"/>	<input type="checkbox"/>	STD: _____
<input type="checkbox"/>	<input type="checkbox"/>	Easily short of breath	YES	NO	Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization for illness or injury, date: _____
YES	NO	Hematologic	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation or Chemotherapy
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Smoker or ex-smoker? How much and # years: _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleed/bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	If you quit, when? _____
YES	NO	Endocrine	YES	NO	Neurologic	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug dependency
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes. Type? _____	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drug use
<input type="checkbox"/>	<input type="checkbox"/>	Average Blood glucose: _____	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's disease	YES	NO	For Females
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? How many months? _____
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Are you breastfeeding?
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Do you use birth control pills?

Other Conditions not listed above:

ALLERGIES – Do you have an allergy to any of the following:

Y	N	Category	Drug Name & Type of Reaction
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	_____
<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic	_____
<input type="checkbox"/>	<input type="checkbox"/>	Aspirin/Ibuprofen/Tylenol	_____
<input type="checkbox"/>	<input type="checkbox"/>	Codeine or other narcotics	_____
<input type="checkbox"/>	<input type="checkbox"/>	Metals (nickel, gold, silver)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Latex	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	_____
		_____	_____

MEDICATIONS (incl. prescription, non-prescription drugs, supplements)

SURGERIES (include approximate date)

Previous Dentist (if any): _____ How long have you been a patient: _____
 Most recent dental exam: _____ Date of most recent X-rays: _____
 I saw my dentist every: 3-4 months 6 months 9 months 12 months Not routinely
 How often do you BRUSH each day? _____ How often to you FLOSS each day? _____
 How would you rate your oral health? Excellent Good Fair Poor

YES NO Please answer the following:

- Are you fearful/anxious about dental treatment? If so, how fearful on a scale of 1 (least) to 10 (most) _____
- Is it important for you to keep your teeth?
- Are you satisfied with the appearance of your teeth?
- Are you satisfied with the function of your teeth?
- Does food frequently get caught between your teeth?
- Do your gums often bleed while brushing?
- Have you noticed loosening of your teeth?
- Have you had any cavities in the past 3 years?
- Are any of your teeth sensitive to cold, hot, or sweet?
- Are any of your teeth tender to biting/chewing?
- Do you have difficulty eating or swallowing?
- Do you have a dry mouth?
- Do you feel that you have bad breath?
- Have you had a change in your ability to taste foods?
- Do you get sores or ulcers in your mouth?
- Have you ever been advised to take antibiotics *before* dental treatment?

YES NO Have you ever had:

- Orthodontic treatment (braces)?
- Oral surgery? Ex. Tooth extraction
- Gum treatment?
- Your bite adjusted?
- A night guard or other appliance?
- Crowns or bridges?
- Dental Implants?
- Complete or Partial dentures?

YES NO TMJ – Have you noticed:

- Clicking of your jaw joint?
- Pain (joint, ear, or side of your face)?
- Difficulty opening or closing?
- Difficulty chewing?

YES NO Oral habits -- Do you:

- Clench or grind your teeth?
- Bite your lips or cheek frequently?

Have you had an unfavorable dental experience or complications with past dental work? If yes, please explain:

Do you have any immediate concerns about your teeth? If yes, please explain:

I, the undersigned, state that I have provided an accurate and complete Medical/Dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding this Medical/Dental history.

Patient/Parent/Guardian Signature: _____ Date: _____

Signature of Dentist: _____ Date: _____