Petrolia Dentistry

Dr. Hoben & Associates, 430 Albany St, Petrolia, Ontario, N0N 1R0

WELCOME TO OUR OFFICE

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? _____

Insurance Information - *Please provide us with information regarding your insurance plan*

☐ No Dental Insurance

☐ Government Program (OW, ODSP, HSO, etc.). Please specify: _____

☐ Private Insurance

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: _____

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POLICY AND CONSENT

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: _____

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MEDICAL HISTORY

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
☐	☐	High blood pressure
☐	☐	Chest pain or tightness
☐	☐	Heart Attack, date: _____
☐	☐	Irregular heart beat
☐	☐	Heart failure
☐	☐	Congenital heart defect
☐	☐	Heart infection or infective endocarditis
☐	☐	Repaired or artificial heart valve
☐	☐	Pacemaker or implantable defibrillator
☐	☐	Stroke, date: _____

YES	NO	Respiratory
☐	☐	Asthma
☐	☐	Emphysema/bronchitis
☐	☐	Sleep apnea
☐	☐	Easily short of breath
☐	☐	Tuberculosis

YES	NO	Hematologic
☐	☐	Anemia
☐	☐	Blood clots
☐	☐	Bleed/bruise easily

YES	NO	Endocrine
☐	☐	Diabetes. Type? _____ Average Blood glucose: ____
☐	☐	Thyroid problem

YES	NO	Renal
☐	☐	Kidney disease
☐	☐	Dialysis

YES	NO	Liver
☐	☐	Liver disease or jaundice
☐	☐	Hepatitis (non-viral)

YES	NO	Gastrointestinal
☐	☐	Indigestion/Acid reflux
☐	☐	Irritable bowel
☐	☐	Stomach/intestinal ulcers
☐	☐	Crohn's or Ulcerative Colitis

YES	NO	Immune
☐	☐	Steroid use in past 2 years
☐	☐	Delayed healing
☐	☐	Stem cell/organ transplant

YES	NO	Musculoskeletal
☐	☐	Arthritis
☐	☐	Osteoporosis/osteopenia
☐	☐	Fibromyalgia
☐	☐	Sjogren's syndrome
☐	☐	Artificial joint, date: _____

YES	NO	Neurologic
☐	☐	Epilepsy or seizures
☐	☐	Parkinson's disease
☐	☐	Multiple sclerosis
☐	☐	Migraines

YES	NO	Eyes/Ears
☐	☐	Glaucoma
☐	☐	Impaired vision
☐	☐	Impaired hearing

YES	NO	Mental Health
☐	☐	Depression/Anxiety
☐	☐	Eating disorder
☐	☐	Sleep disorder
☐	☐	Bipolar disorder
☐	☐	Dementia
☐	☐	Learning disorder

YES	NO	Infections
☐	☐	HIV or AIDS
☐	☐	Hepatitis: Type? _____
☐	☐	STD: _____

YES	NO	Other
☐	☐	Hospitalization for illness or injury, date: _____
☐	☐	Cancer: _____
☐	☐	Radiation or Chemotherapy
☐	☐	Smoker or ex-smoker? How much and # years: _____ If you quit, when? _____
☐	☐	Alcohol/Drug dependency
☐	☐	Recreational drug use

YES	NO	For Females
☐	☐	Are you pregnant? How many months? _____
☐	☐	Are you breastfeeding?
☐	☐	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
☐	☐	Antibiotics	
☐	☐	Local Anesthetic	
☐	☐	Aspirin/Ibuprofen/Tylenol	
☐	☐	Codeine or othernarcotics	
☐	☐	Metals (nickel, gold, silver)	
☐	☐	Latex	
☐	☐	Other: _____	
		_____	

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

_____

_____

_____

_____

_____

SURGERIES (include approximate date)

_____

_____

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DENTAL HISTORY

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: _____