Packham Avenue Dental

Personal Information

Name:_____ M____ F____ Date of Birth_____/_____/_____(D/M/Y)
Parents name (if patient is a minor):_____
Address:_____ City:_____ Postal Code:_____
Phone: (H)_____(W)_____ (C)_____
Email:_____
Emergency Contact:_____ Phone:_____
Physician:_____ Phone:_____ Health Card #:_____

Insurance Information

1st Insurance Company:_____ Policy #:_____ ID#:_____
2nd Insurance Company:_____ Policy #:_____ ID #:_____
Occupation:_____ Place of Employment:_____
Treaty Number:_____ Band:_____

Medical Information

1. List all drugs(prescription, non-prescription, herbal) that you are presently taking are have recently taken:_____
2. Do you have any allergies? (please list)_____Epipen required?_|Y( ) N( )
3. Do you smoke or use chewing tobacco? (circle) YES NO
4. Do you have or had any of the following? (please check)

__heart attack	__stroke	__HIV or AIDS	__angina pectoris
__stomach ulcer	__arthritis	__heart failure	__chronic bronchitis
__organ transplant	__cancer	__artificial joint	__under-active thyroid
__irregular heart beat	__epilepsy	__blood disease	__over-active thyroid
__tuberculosis	__hepatitis	__rheumatic fever	__psychiatric disorder
__liver impairment	__seizure	__emphysema	__fainting spells
__artificial heart valve	__diabetes	__heart defect	__high blood pressure
__bleeding disorder	__pacemaker	__medical implant	__heart murmur
__ asthma			

5. If you have Diabetes do you have type 1 or type 2? (circle) Type 1 Type 2
6. Please note any disability, condition, or problem you have not listed above: _____
7. Are you pregnant or nursing? (circle) YES NO If yes how many weeks? _____

Oral Health Information

1. What is your main concern about your mouth?_____
2. Are you nervous about dental treatment? YES NO
3. Have you had any of the following conditions/treatments? (please check)

__dental implants	__uncomfortable jaw	__tooth whitening	__root canal therapy
__bleeding gums	__jaw joint noises	__gum surgery	__crowns or bridges
__loose teeth	__jaw locking	__dentures	__TMJ(jaw joint) treatment
__injured teeth	__tooth extractions	__clenching/grinding	__ortho braces/appliances
__tooth aches	__sensitive teeth	__oral surgery	__oral peircing

4. When was your last complete exam by a dentist? _____
5. When was your last cleaning by a hygienist? _____
SIGNATURE:_____ **DATE:**_____

Patient Financial Agreement

Packham Avenue Dental
116-335 Packham Avenue Saskatoon, SK S7N 4S1

As a courtesy, we will collect fees for provided services directly from a patient's insurance.

I _____ (patients name) understand that the fees listed on the insurance claim may not totally be recovered or may exceed my plan benefits. I understand that:

1) I am financially responsible to Packham Avenue Dental for the fees not payable by the insurance company on the day service is rendered.

2) I understand that in the event we are not able to recover all of the expected amount from insurance that I the patient/guardian of the patient will be responsible to pay this amount to Packham Avenue Dental.

Interest will be charged on overdue accounts past 30 days and will be charged on a monthly basis on outstanding balance of the non-insured fees

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Patient Agreement

I also understand that I am fully responsible for attending any appointments that I schedule with Packham Avenue Dental.

1) I agree to provide 2 full business days notice to change or cancel any appointments I schedule at Packham Avenue Dental in the event that the patient does not provide the required notice we reserve the right to charge a fee for any missed or canceled appointments.

2) Patient agrees to allow affiliates of Packham Avenue Dental to sign insurance forms on their behalf in the event that insurance requests this information.

Booking appointments for any patient is at the sole discretion of the staff and dentists of Packham Avenue Dental.

Patient Signature _____ **Date** _____