GARRISON WOODS
DENTAL

Date: _____

**PATIENT INFORMATION**

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

Email: _____ Cell: _____ Home Phone: _____

Emergency Contact Name: _____ Relationship: _____Phone: _____

How did you hear about us? _____

**INSURANCE INFORMATION**

Policy Holder Name: _____ Relationship: _____ Date of Birth: _____

Insurance Company: _____ Employer:_____

ID/Certificate No.:_____ Group/Plan/Contract No.:_____

If you have secondary insurance, please complete the following:

Policy Holder Name: _____ Relationship: _____ Date of Birth: _____

Insurance Company: _____ Employer:_____

ID/Certificate No.:_____ Group/Plan/Contract No.:_____

**MEDICAL INFORMATION**

Family Physician: _____ Phone: _____

How would you describe your overall health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Are you currently taking any medications? ◯ Yes ◯ No

If yes, please list current medications: _____

Do you have any allergies? ◯ Yes ◯ No. If yes, please list: _____

Do you require pre-treatment medications? ◯ Yes ◯ No. If yes, please list: _____

Do you smoke? ◯ Yes ◯ No

Woman only – is there any possibility of being pregnant at this time? ◯ Yes ◯ No

Do you or have you ever had any of the following? (please check)

- ☐ Angina
- ☐ Arthritis
- ☐ Artificial limbs or joints
- ☐ Blood disorders
- ☐ Breathing problems
- ☐ Diabetes
- ☐ Epilepsy or seizure
- ☐ Heart conditions: _____
- ☐ Hepatitis or liver disease
- ☐ Herpes / cold sores
- ☐ High or low blood pressure
- ☐ HIV positive
- ☐ Hormonal disorder
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Surgery: _____
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Tumors or cancer

Are you immunocompromised? ◯ Yes ◯ No.

Is there any condition not listed that we should know about? ◯ Yes ◯ No. If yes, please list:_____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. _____ (please initial).

GARRISON WOODS
DENTAL

Date: _____

**DENTAL HISTORY**

Previous dentist name and location: _____Last dental visit: _____ Last hygiene visit: _____

| | | | |
|---|---|---|---|
| Do your gums bleed while brushing or flossing? | ◯Yes ◯No | Have you had any pain in your jaw area? | ◯Yes ◯No |
| Have you ever had Orthodontic Treatment? | ◯Yes ◯No | Do food frequently get caught in your teeth? | ◯Yes ◯No |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ◯Yes ◯No | Do you bite your lips or cheeks frequently | ◯Yes ◯No |
| Do you feel pain to any of your teeth | ◯Yes ◯No | Do you have any loose teeth or have they ever shifted? | ◯Yes ◯No |
| Have you ever had a head, neck or jaw injury? | ◯Yes ◯No | Have you ever had Periodontal Treatment? | ◯Yes ◯No |

If you have a current dental problem, please describe: _____

Are you happy with the appearance of your teeth? ◯Yes ◯No. If not, please explain: _____

**FINANCIAL AGREEMENT**

Payment in full is due the day of treatment, or on upon the start of major treatment. Should a patient have dental insurance with assignment to Garrison Woods Dental, the estimated patient portion will be the amount due. For your convenience we accept Cash, Debit, Visa, MasterCard.

For patients with dental insurance: Dental insurance plans often pay less than the actual fee for service. Therefore, the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. You are ultimately responsible for all costs incurred regardless of what your dental insurance covers.

**CANCELLATION POLICY**

We do require 2 business days notice to change your appointment or a cancellation fee may apply. _____ (please initial).

**PRIVACY POLICY**

We are committed to protecting the privacy of our patients' personal information & to utilizing all personal information in a responsible and professional manner.

- Patient personal information is collected and used for the purpose of updating personal profiles, invoicing, processing insurance claims, sending reminders and sending information to patients about our dental practice.
- Patient medical information is collected and used for the purpose of diagnosing dental conditions, treatment planning and providing dental treatment
- Patient financial information may be collected in order to make arrangements for the payment of dental services provided.

I authorize Garrison Woods Dental to release any information regarding my dental/medical history, diagnosis or treatment to specialists, other dental offices, or health care provides as required or requested by myself. _____ (please initial).

**INFORMED CONSENT**

I, the undersigned, do hereby authorize and consent to the administration of dental procedures mutually deemed necessary or advisable for myself, or my child, by the attending dentist, including but not limited to, the use of local anesthetics, or other prescribed medications.

I shall assume the responsibility for payment of all fees associated with treatment procedures provided.

I consent to collection, use and disclosure of my personal information for the purposes outlined in the privacy policy.

I have reviewed the foregoing consent and authorization, and understand its content.

Patient/Parent or Guardian Signature: _____