Petras FAMILY DENTAL

Welcome to our dental practice! We appreciate the opportunity to help you with your dental needs. Providing this information helps us to treat you safely and efficiently. All information provided is confidential.

Patient Name_____

Birthdate (dd/mm/yyyy)_____ Age_____

Street Address_____

City_____Postal Code_____

Home Phone_____ Cell Phone_____

Email_____

Employer_____

Responsible Parent/Guardian (If patient is a minor):

Name_____

Relationship to patient _____

Emergency Contact

Name_____

Phone Number_____

Relationship to patient _____

PRIMARY INSURANCE INFORMATION (If applicable)

Name of policyholder _____

Date of birth of policyholder (dd/mm/yyyy)_____

Insurance Company _____

Policy No_____Subscriber ID number _____

Place of employment_____

Relationship of patient to policy holder: Self / Spouse / Dependent ☐ ☐ ☐

SECONDARY INSURANCE INFORMATION (If applicable)

Name of policyholder _____

Date of birth of policyholder (dd/mm/yyyy)_____

Insurance Company _____

Policy No_____Subscriber ID number _____

Place of employment_____

Relationship of patient to policy holder: Self / Spouse / Dependent ☐ ☐ ☐

Preferred method of contact to book appointments:

☐ Phone ☐ Email

Who may we thank for referring you to our office?_____

Referrals are always appreciated!

Payment is due on treatment date if not covered by your insurance plan. Overdue accounts are subject to a 1.75% charge per month (minimum charge of $5 per month). Patient is to cover costs of collection, if necessary.

Insurance plans are confidential agreement between you and your insurance company. Written estimates can be provided to assist in processing of your dental benefits. You are responsible for any amount not covered by your dental plan.

I certify that the medical information provided on the following form is accurate and correct to the best of my knowledge.

I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described, to the named dentist.

Our Office wants to assist you and all our patients by minimizing wait times between appointments. Last minute cancellations or no shows delay your treatment and the treatment for other patients who could have used that appointment time. **We require 48 hours notice to cancel or reschedule an appointment to avoid a $40.00 cancellation fee.**

I consent to the release of information as set out in our privacy policy.

_____ _____

Signature of patient, parent or guardian Date

The following information is required for our dental professionals to provide you with the safest possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. Please fill in the form as completely as possible. The dentist will review the questions and explain any questions that you do not understand

1. Are you currently being treated for any medical condition at the present, or within the past year? ☐ Yes / No ☐

   _____

2. When was your last medical checkup?_____
   a. Was there any specific findings?_____
   b. Name of your Medical Doctor:_____
   c. Medical Doctor's phone number:_____
3. Are you currently taking any medications, non-prescription drugs, or herbal supplements?

   _____

   If yes, please list pharmacy:

   _____
4. Do you have any allergies? Use the following categories:
   Medications: _____
   Latex/rubber/metals: _____
   Other (hayfever, foods, etc.) _____
   a. Do any of these allergies lead to breathing problems?

   _____

5. Do you have any reactions to dental injections? ☐ Yes / No ☐
6. Do you have, or ever had asthma? ☐ Yes / No ☐
7. Do you have emphysema, bronchitis, or COPD? ☐ Yes / No ☐
8. Do you have, or ever had blood pressure problems? ☐ Yes / No ☐
9. Do you have, or ever had any chest pain? ☐ Yes / No ☐
10. Any history of heart valve replacement or repair? ☐ Yes / No ☐
11. Have you ever had total joint replacement? ☐ Yes / No ☐
12. Have you ever had a heart attack in the past? ☐ Yes / No ☐
13. Have you ever had a stroke in the past? ☐ Yes / No ☐
14. Do you have a pacemaker inserted? ☐ Yes / No ☐
15. Do you have, or ever had leukemia? ☐ Yes / No ☐
16. Do you have, or ever had HIVS or AIDS? ☐ Yes / No ☐
17. Do you have, or have ever had hepatitis? ☐ Yes / No ☐
18. Do you have, or ever had cancer? ☐ Yes / No ☐
19. Do you have, or ever had radiation therapy? ☐ Yes / No ☐
20. Do you have, or ever had chemotherapy? ☐ Yes / No ☐
21. Do you have, or ever had osteoporosis? ☐ Yes / No ☐
22. Have you ever taken bisphosphonate medications? ☐ Yes / No ☐
23. Are you currently taking any steroid therapy? ☐ Yes / No ☐
24. Do you have a bleeding disorder? ☐ Yes / No ☐
25. Have you ever been diagnosed with diabetes? ☐ Yes / No ☐
26. Do you have, or ever had kidney disease or transpla☐ Yes / No ☐
27. Do you have, or ever had stomach ulcers? ☐ Yes / No ☐
28. Do you have, or ever had a seizure before? ☐ Yes / No ☐
29. Do you have, or ever had tuberculosis? ☐ Yes / No ☐
30. Have you ever been hospitalized for any reason (include year)?

    _____

    _____

    _____

31. Do you smoke or chew tobacco? ☐ Yes / No ☐
32. Do you have, or ever had drug/alcohol dependency? ☐ Yes / No ☐
33. Are you nervous during dental treatment? ☐ Yes / No ☐
34. Date of last dental treatment? _____
35. Name of previous dentist?_____

36. For women only:
    a. Are you currently pregnant? ☐ Yes / No ☐
    b. Are you currently breastfeeding? ☐ Yes / No ☐
    c. Are you currently taking an oral contraceptiv☐ Yes / No ☐
37. Any other medical concerns not listed above?_____

Petras FAMILY DENTAL

165 Sandwich St. S
Amherstburg, ON N9V 1Z9
Phone: (519) 713-8985 Fax: 888-920-1230
Email: petrasfamilydental@gmail.com

Dr. _____

I, _____ have recently become a patient of Petras Family Dental.
Patient Name (please print)

Please provide them with a paper or digital copy of:

☐ Date of last new patient/recall exam.

☐ Date of last BW radiographs (please provide a copy if less than 1 year old)

☐ Date of last Panoramic radiograph (please provide a copy if less than 3 years old)

☐ Copy of progress notes

Please forward digital chart/radiographs to petrasfamilydental@gmail.com or provide on CD.

I authorize the release of all requested dental records to Petras Family Dental.

_____
Patient Name (please print)

_____
Patient Signature

_____
Date

PETRAS
FAMILY DENTAL

INSURANCE COVERAGE INFORMATION

We know how complicated and confusing insurance plans can be! Our administration staff spends countless hours every day trying to figure out the details of your dental insurance coverage.

Due to privacy laws, many insurance companies will only provide our staff members with minimal or no information regarding your plan. This can delay your dental treatment or lead to unexpected responses when your insurance is billed.

To aid you, we are providing you with instructions on how to contact your insurance company to get a complete understanding of your dental insurance plan. Please ask the insurance representative the following questions and fill in the blanks with their responses:

Green Shield - 519-739-1133
Manulife Insurance - 888-844-8889
Canada Life - 800-957-9777
Desjardins Insurance - 800-263-1810
Sunlife Insurance - 800-361-2128
Blue Cross Insurance - 800-873-2583
RWAM Insurance - 877-888-7926
Claimsecure Insurance - 888-513-4464

1) What is my yearly maximum on my plan? _____
2) What is my Basic coverage maximum? _____, and at what percentage? _____%
3) What is my Major coverage maximum? _____, and at what percentage? _____%
4) Is my Basic & Major coverage combined or separate? _____
5) What date does my plan renew? _____
6) What is the yearly fee schedule for my plan? _____
7) Does my plan have a deductible charge? _____
8) How often am I covered for a recall exam? _____
9) How often am I covered for Bitewing x-rays? _____
10) How often am I covered for Panoramic x-rays? _____
11) How many scaling units are covered per year? _____
12) How often am I covered for a polish?_____
13 How often am I covered for fluoride? _____ Is there an age restriction? _____
14) Is nitrous oxide sedation covered in my plan? _____
15) Do I have orthodontic coverage? _____

Please provide a copy of this to our office in-person or via email (petrasfamilydental@gmail.com), and this will aid our team greatly in understanding your dental insurance provider's coverage obligations!