B|Y|S DENTAL *BRICKYARD STATION DENTAL*

Welcome to Our Office

In order to prevent any misunderstanding regarding payment for treatment, we would like you to be aware of the following:

- We will gladly process and submit claims to your dental insurance company for direct payment to us provided that you give us the complete detailed information required regarding the coverage that you have (Group/Policy/Certificate/ ID numbers, percentage of coverage, annual limits, deductibles, frequency of certain procedures and procedure for submitting the claim etc.)
- We must stress that **the patient is directly responsible for payments for all treatment** and you should be aware of what your insurance plans limitations are. Most fees charged are based on the current BC Dental Association Fee Guide. It cannot be assumed that your insurance company will reimburse based on the same fee guide and may also have limitations pertaining to specific procedures. We will do our best to inform you of what your insurance company will pay for treatment recommended.
- **Payment of your percentage is due at the time of service.**
- Claims to insurance companies that have not been paid within six weeks of the treatment date may be transferred and billed directly to the patient for payment.
- **If you do not have dental insurance, payment is due at the time of service.**

Please help us to maintain the operation of our office on sound and efficient principles so that we may assure you and other patients of uninterrupted treatment.

Remember, that once you have made an appointment, that **time is reserved exclusively for you**. Although we attempt to remind our patients of their appointment times, this is only a courtesy and the booked times are the patient's responsibility. A minimum of 48 hours' notice is required to change or cancel any appointment to avoid a missed appointment fee. Please avoid this situation. We dislike for lost time as much as our patients dislike paying for it.

☐ I agree to receive Brickyard Station Dental office communications by email or text messaging, including appointment reminders. You can withdraw your consent at any time by informing the administrative staff.

Date: _____

Patient Name: _____

Patient or Parent/ Guardian Signature: _____

CONFIDENTIAL PATIENT REGISTRATION

Welcome to our dental practice. Please complete the following important information.

Patient Information

Mr./Mrs./Ms/Miss/Dr. (please circle one)

First name:_____Last name:_____

Preferred name:_____

Birthdate M/D/Y: _____

Address:_____Postal Code:_____

Homephone:_____Cellphone:_____Workphone:_____

Preferred daytime contact number: (√) H___ C___ W___

Email:_____

Emergency contact: _____ Relationship to patient: _____

Daytime phone:_____ Cell phone:_____

Family physician: _____

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

Insurance Information

Policy holder:_____Relationship to patient:_____

Policy holder birthdate M/D/Y:_____

Employer:_____Work phone:_____

Insurance company_____

Group/Policy #:_____Certificate/Div/ID #:_____

Coverage: Basic:_____% limit: $_____ Major:_____% limit: $_____

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

_____ _____

Signature of patient or parent/guardian of minor Date

CONFIDENTIAL MEDICAL HISTORY

Physician's name_____ Phone #_____

1. Are you in good health? Yes ____ No ____ If no, please provide details_____
   _____
2. When was the last time you had a medical examination? _____
3. Are you presently receiving treatment for any illness? If yes, please provide details:_____
   _____
4. Have you ever been hospitalized? If yes, please provide details_____
   _____
5. Do you have any heart or circulatory problems? Yes ____ No ____
6. Do you have a pacemaker? Yes ____ No ____
7. Have you ever had rheumatic fever? Yes ____ No ____ If yes, when_____
8. Have you ever been advised to take pre-medication prior to dental treatment? Yes ____ No ____
9. Do you have allergies? Seasonal/ Hay Fever _____ Food _____
   Medications_____ Other_____
10. Are you presently taking any kind of medication? If yes, please specify:
    Drug _____ Reason _____
    Drug _____ Reason _____
11. Have you ever had a reaction to any kind of medicine or dental local anesthetic? If yes, please provide details: _____
12. Female Patient- Are you pregnant or think you may be pregnant? Yes ___ No ___
13. Please indicate below (√) if you **presently have** or **have ever had any** of the following:

☐AIDS/ HIV	☐Fainting/ dizzy spells
☐Alcohol or Chemical dependency	☐High/ Low blood pressure
☐Arthritis or Rheumatism	☐Hyper/ Hypo glycemia
☐Asthma	☐Kidney disease
☐Blood transfusion	☐Liver disease (Hepatitis/ Jaundice)
☐Cancer/ Radiotherapy/Chemotherapy	☐Lung disease/ Chest pain
	☐Mental or Nervous disorder
☐Diabetes	☐Stomach ulcer
☐Eating disorder	☐Stroke
☐Epilepsy/ seizures	☐Tuberculosis

14. Do you smoke? If yes, how much per day? __ _____ per week? _____
15. Do you grind or clench your teeth? Yes ___ No ___
16. Do you suffer from headaches____ ear aches_____ or neck aches_____?

Is there any additional information related to your health that has not been addressed above?

_____

_____

_____ _____

Signature of patient or parent/guardian of minor **Date**

PATIENT DENTAL HISTORY

Reason for this visit_____

Last dental visit (date) _____ Treatment provided at that time_____

Frequency of dental visits_____ Previous Dentist (name and location)

_____

Have you had a complete series of dental films/x-rays taken? _____ Where? _____

When? _____ Can we request these be sent to this office? _____

Please indicate below (√) if you **presently have** or **have ever had any** of the following:

- ☐ Do your gums bleed while brushing or flossing?
- ☐ Are your teeth sensitive to hot or cold?
- ☐ Are your teeth sensitive to sweets or sour?
- ☐ Do you feel pain in any of your teeth?
- ☐ Do you have any sores or lumps in or near your mouth?
- ☐ Have you ever had any head, neck or jaw injuries?
- ☐ Have you ever experienced any of the following problems in your jaw?
- ☐ Clicking
- ☐ Pain (joint, ear or side of face)
- ☐ Difficulty in opening/closing
- ☐ Difficulty in chewing
- ☐ Do you have frequent headaches?
- ☐ Do you clench or grind your teeth?
- ☐ Do you bite your lips/cheeks frequently?
- ☐ Have you noticed any loosening of your teeth?
- ☐ Does food get caught between your teeth?
- ☐ Have you had periodontal (gum) treatment?
- ☐ Have you received oral hygiene instruction for the care of your teeth and gums?
- ☐ Have you had difficult extractions before?
- ☐ Have you had prolonged bleeding from extractions before?
- ☐ Do you wear dentures or partials?
- ☐ If yes, date of placement_____
- ☐ Do you have dental implants?
- ☐ If yes, date of placement _____
- ☐ Have you had orthodontic treatment?
- ☐ If yes, date of completing _____
- ☐ Have you had treatment from a dental specialist? If yes, what type? _____

Additional comments or concerns? _____

_____ _____

Signature of patient or parent/guardian of minor **Date**