

Welcome to

Harmony DENTAL CARE

(Please fill out both sides.)

Confidential Patient Information

Patient Name: _____ Male Female
Last First MI
 Married Single Child Other _____ BirthDate: (DAY / MONTH / YEAR) _____
 Name of Spouse _____ Names of Children _____
 Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
 Mobile _____ Email _____
 Address: _____
Street Apartment #

City Province Postal Code

Health Information

Name of Previous Dentist: _____ Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Growths | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Hay Fever | Due date: _____ | <i>Please list your</i> |
| _____ | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Radiation Treatment | <i>Medications:</i> |
| _____ | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Respiratory Problems | _____ |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatism | _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Sinus Problems | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Smoking | _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Condition | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tumors | _____ |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Ulcers | _____ |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease | _____ |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Codeine Allergy | _____ |

- Have you ever had any complications following dental treatment? No Yes, please explain: _____
- Have been to a hospital or needed emergency care during the past two years? No Yes, please explain: _____
- Are you now under the care of a physician? No Yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? : _____

Is there anything else you would like to add to help us make your visits more comfortable?

Referral Information

Whom may we thank for referring you to our practice?

- Another patient, _____
 Shopping in Plaza Yellow Pages Book Google Website
 Road Sign Yellowpages.ca Other: _____

Special Concerns:

Are you nervous about dental treatment? no yes _____
Would you like more information on tooth whitening? no yes _____
Would you like more information on braces? no yes _____
Are you aware of night time tooth grinding? no yes _____
Do you require a sports mouth guard? no yes _____

If someone else is responsible for your account please fill out this box,

Name of Person Responsible for Account: _____
 Male Female
Birth Date: _____ Married Single Child Other _____
Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____
Street Apartment #
City Province Postal Code

Insurance Holder's Information

Primary Insurance Plan

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: (if different from patient's Address)
Street City Province Postal Code
Insured's Employer Name: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name: _____

Secondary Insurance Plan

Name of Insured: _____ Is insured a patient? Yes No
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Address: (if different from patient's Address)
Street City Province Postal Code
Insured's Employer Name: _____
Patient's relationship to insured: Self Spouse Child Other _____
Insurance Plan Name: _____

Please initial all applicable items:

___ I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.
___ I hereby assign my benefits payable from claims submitted electronically or by mail to the dentists of Harmony Dental Care and authorize payment directly to him/her.
___ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Financial Policies

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility.
A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.
All estimates for care are approximate.
I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, guardian, or guarantor of payments Date: _____ Relationship to Patient: _____

Printed Name of patient, parent, guardian, or guarantor of payments