

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 Dr. P. Yao, Dr. K. Lung, Dr. B. Castillo, Dr. R. Fisher, Dr J. Nikolovski, or Dr. D. Leung 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