New Patient Forms

ESSENCE DENTAL

Patient Name:	**Date of Birth:**
Gender: ☐ Male ☐ Female	
Parent/Guardian:	
I would preferred to be called:	
☐ Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor	

CONTACT INFORMATION

Home Address:
City:
Postal Code:
Please check your preferred method of contact
☐ Home Phone:
☐ Mobile Phone:
☐ Email:
Are you a full-time or part-time student?
School:

Reason for this visit:
Date of last dental visit:
Family who are patients:
How did you hear about us?

Emergency Contact

Name:
Relation:
Phone:

INSURANCE INFORMATION ☐ **No Insurance**

Primary Coverage
Employee Name:
Date of Birth:
Employer:
Business Location:
Occupation:
Insurance Company:
Policy #:
Certificate #:
Secondary Coverage
Employee Name:
Date of Birth:
Employer:
Business Location:
Occupation:
Insurance Company:
Policy #:
Certificate #:

Release

- I authorize the dentist to preform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advie and treatment to another dental specialist or health care provider, only if deemed necessary for the beneficial health care of the patient.

Consent

- Patients who carry dental insurance understand that all dental services are charged directly to their insurance company. **This practice accepts assignment of benefits; however, co-pay amounts not covered by insurance including deductibles must be paid at the time of service.**
- **All dental services requiring laboratory work require a deposit. This deposit will be deducted from the patient's balance, or, will be returned to them once payment in full has been reimbursed from the insurance company.**
- Patients who carry dental insurance understand that all dental services furnished are charged directly to their insurance company, however, any differences become the personal responsibility of the patient or guardian in the case of a minor.
- I understand that interest will be added to any balances 90 days past due and an administration fee of $100 will be added to any account that goes to collections.

I have read the above conditions of release and consent and agree to their content AND attest to the accuracy of the information provided on this page.

Patient/Guardian Signature **Date:**

MEDICAL HISTORY ON REVERSE

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Patient Name: **Date of Birth:**

	Doctor:
Allergies to Latex? YES NO	**Last Complete Physical:**
Allergies to Metals? Type	**PreMed Required?**
Allergies to Medications? Type	**Type:**
Other Allergies?	**Reason:**

CURRENT MEDICATIONS (Prescription, Over the Counter, Herbal & Daily Aspirin)

Medication	Dosage	Frequency	Reason

PAST AND CURRENT MEDICAL CONDITIONS (check all that apply)

Hospitalization/Operation(s) in last 5 years? Details:		**Use tobacco products? How long used? How long quit?**	
Under a doctor's care (other than general visits)		**Issues with penicillin, antibiotics anesthetics?**	
Head/neck/mouth injuries?		**Blood disorders? Eg: anemia, leukemia**	
Women: Pregnant		**Excessive bleeding?**	
Women: Oral contraceptives?		**Stomach issues?**	
Heart trouble/disease?		**Kidney issues?**	
Heart murmur?		**Liver issues?**	
Artificial heart valve implants?		**Diabetes: Type Controlled? Y/N**	
Heart surgery?		**Asthma? Controlled?**	
Pacemaker?		**Epilepsy/seizures?**	
High blood pressure?		**HIV+/AIDS?**	
Low blood pressure?		**Hepatitis?**	
Rheumatic fever?		**Tuberculosis?**	
Cancer?		**Alcohol or chemical dependency?**	
Radiation?		**Other Issue not listed:**	
Chemotherapy?			
Artificial joints/prosthesis?		**I would like to talk to the Doctor privately about something.**	
Inflammatory disease (arthritis/rheumatism)			
Notes:			

I certify that the above information is complete and accurate.
Patient/Guardian Signature: **Date:**

Dentist's Signature: **Date:**