SINGHAL DENTISTRY

New Patient Adult

1 Patient Details Please print clearly

First Name:

Last Name:

Preferred Name:

Date of Birth: Sex:

Marital Status: Married Single CommonLaw Other

Occupation:

Home Address:

City:

Province:

Postal Code:

Home Telephone:

Work Telephone:

Mobile Telephone:

E-mail:

How did you hear about us? Please check all that apply.

☐ Website
☐ Driving by location(s)
☐ Live/work nearby
☐ Online Search (Google)
☐ Printed Advertisements
☐ Other:

☐ I was referred by one of your patients:

_____

☐ Other family members seen by us:

1. _____
2. _____
3. _____
4. _____
5. _____

2 Medical History Please print clearly

Name of Medical Doctor:

Doctor Telephone:

Have you had any problems with your general health within the past five (5) years?
☐ No ☐ Yes
If yes, please give details:

Are you currently taking any medications?
Please list all medications below.

1. _____
2. _____
3. _____
4. _____
5. _____

Are you a smoker? ☐ No ☐ Yes

For Women:

Are you taking birth control pills? ☐ No ☐ Yes
Are you pregnant? ☐ No ☐ Yes
Are you nursing? ☐ No ☐ Yes

Do you have a medical condition that requires you to take antibiotics before receiving dental treatment?
☐ No ☐ Yes
If yes, please give details:

2 Medical History (continued) Please print clearly

Have you been diagnosed with any of the following conditions? Please check all that apply.

- ☐ Asthma
- ☐ Mental/Nervous Disorders
- ☐ Shortness of Breath/Chest Pain
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Kidney/Liver Disease
- ☐ Back Problems/Surgery
- ☐ Hemophilia/Blood Disease
- ☐ Artificial Joints
- ☐ Heart Valve
- ☐ Heart Condition
  Please specify: _____
- ☐ Cancer
  Please specify: _____
- ☐ Allergies
  Please specify: _____
- ☐ Other
  Please specify: _____

3 Dental History Please print clearly

Previous Dentist:		Date of Last Visit:	
Do you floss daily?	☐ No ☐ Yes	Are you happy with your smile?	☐ Yes ☐ No
Do you brush daily?	☐ No ☐ Yes	Would you like a whiter smile?	☐ Yes ☐ No
Do your gums ever bleed?	☐ No ☐ Yes	Do you experience discomfort in your jaw?	☐ Yes ☐ No

Are your teeth sensitive to any of the following? ☐ Heat ☐ Cold ☐ Sweet ☐ Pressure ☐ Not applicable

4 Insurance Please print clearly

List PRIMARY insurance information below:	List SECONDARY insurance information below:
Insurance Company:	Insurance Company:
Insurance plan/Group/Contract Number:	Insurance plan/Group/Contract Number:
Certificate/ID Number:	Certificate/ID Number:
Name of Insured:	Name of Insured:
Date of Birth of Insured: DD/MM/YYYY	Date of Birth of Insured: DD/MM/YYYY
Relationship to Patient:	Relationship to Patient:

5 Payment

We are a fee-for-service dental provider. **Payment is due in full at the time dental treatment is rendered.** We do not accept direct payment from insurance companies. If you have dental insurance, we will gladly submit your claim electronically, whereby you will be reimbursed directly by your insurance carrier, usually within three to five business days (for cheques), or within 48 hours (for direct deposit).

We accept cash, Visa, MasterCard and Interac payments for all goods and services.

6 Consent to Submit Dental Claims Electronically

I authorize release, to my benefits plan administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. Singhal, Dr. Chopra and their associate dentists.

This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient, parent or legal guardian:	Date:

7 Authorization and Consent for Treatment

I certify that I have provided an accurate and complete personal and medical-dental history and I have not knowingly omitted any information.

I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

I authorize the doctor to perform treatments and therapies that may be indicated (with my further consent) and I also consent to the use of local anesthetic agents.

I UNDERSTAND THE PREVIOUS STATEMENTS REGARDING PAYMENT OF FEES AND ACCEPT THE RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED FOR MYSELF AND/OR MY DEPENDENTS, DUE AND ARE PAYABLE WHEN SERVICES ARE RENDERED, UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE PRIOR.

☐ I authorize Dr. Singhal, Dr. Choprta and their associate dentists to release any information required to process my dental insurance claims.

☐ I understand that I am responsible for payment of the full balance on my account.

Signature of patient:	Date: DD/MM/YYYY
Signature of parent or responsible party:	Relationship to Patient:

8 Appointment Cancellation Policy

At Singhal Dentistry, appointments are made in advance by reserving the appropriate time slots to accommodate you and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing and arranging set-up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on.

Therefore, we kindly ask for **at least two (2) business days notice prior to any appointment changes or cancellations, so that we are able to waive the customary $50 cancellation charge** a fee to offset some of the lost production and appointment preparation costs associated with your treatment. In addition, we can offer your appointment time to another patient. We appreciate your help in this matter.

Signature:	Date: DD/MM/YYYY