

PATIENT PERSONAL HISTORY

Mr. _ Mrs. _ Ms. _ Miss _ **Name** Last: _____ First: _____ Mid: _____

Address: Apt# _____ - _____

City: _____ Prov: _____ Postal Code: _____ - _____

Birth Date: ___/___/___ Age: ___ Sex: ___ Height: ___ Weight: ___ Birth Place: _____

Cell#: _____ - _____ Work#: _____ - _____ Ext: ___ Home#: _____ - _____

Email Address: _____ @ _____

Best method of contacting you - Phone call _____ text message _____ email _____ other _____

Employer: _____ Occupation/Dept: _____

Referred by: _____ Relative: _____ # _____

Family Physician: _____ Phone#: _____

Previous Dentist: _____ Phone#: _____

We require pre-signed dental claim forms with DUAL insurance coverage.

Primary Insurance: No ___ Yes ___ Ins.Co.: _____

Name of Insured: _____ Birth Date: ___/___/___

Employer's Name: _____ Phone#: _____

Group/Policy #: _____ ID#: _____ Subscriber SIN#: ___/___/___

Dual Insurance: No ___ Yes ___ Ins.Co.: _____

Name of Insured: _____ Birth Date: ___/___/___

Employer's Name: _____ Phone#: _____

Group/Policy #: _____ ID#: _____ Subscriber SIN#: ___/___/___

WELCOME

As a new patient of **BARTLEY'S SQUARE DENTAL OFFICE**, we welcome you & your family to a dental practice dedicated to maintaining your oral health. This office is equipped with modern dental equipment operated by highly trained dentists and staff. This office also meets or exceeds all government required standards for sterilization. This is yet another way we strive to assure your continued comfort and health.

The Canadian Dental Association, in conjunction with provincial associations, insurance Carriers, network suppliers and dental system vendors, has established a network that allows us to submit claims and pretreatment plans electronically. This network is called CDAnet.

| authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.

Signature of patient/guardian _____

As a COURTESY to our patients, we will complete all dental insurance claim forms & submit them on behalf of our patients, electronically, by courier or by mail, (provided the plan administrators' authorization is not required), Assignment will be accepted for most plans. Please complete the following:

| hereby assign my benefits payable from claims submitted electronically or manually to my dentist at Bartley's Square Dental Office and authorize payment directly to the dental office.

Signature of patient/guardian, subscriber _____

Occasionally appointments are cancelled with less than 24 hours notice. This leaves us with openings that are impossible to reschedule. While we do attempt to remind our patients of their appointments, this is only a COURTESY which at times may be impossible to provide. We require 48 hours of notice of cancellation. Failure to do so may necessitate a charge of \$250.00 to your account. PLEASE TRY TO AVOID THIS SITUATION.

To further assist us, **PLEASE** complete the following:

Has an initial exam been charged to your current insurance policy within the past 3 years? ()yes ()no

Has a full series or panorex x-ray been taken within 3 years? ()yes ()no

_____ I fully understand and agree that should my insurance not pay 100% of my dental costs, | accept FULL RESPONSIBILITY to pay the balance in full.

_____ I have no insurance coverage at this time and do agree to make payments in full by cash, debit or credit card payment on completion of each scheduled appointment, unless other arrangements are made with the Manager or Dentist PRIOR to treatment.

I authorize Dr. Steve Monardo, Dr. Tony Keran and the staff of Bartley's Square Dental Office to send correspondence to me via email.

TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION | HAVE SUPPLIED IS CORRECT.

_____ Date: _____

Signature of patient, parent/guardian