DOUGLASDALE DENTAL

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NEW PATIENT INFORMATION

Patient Name _____Date_____
Address_____
City_____ Postal Code_____
Sex □F □M Birthdate (DD/MM/YY)_____Email_____
Phone (H)_____(B)_____(C)_____
In case of emergency, Contact not living at your home _____
Contact's Phone Number_____
IF PATIENT IS A MINOR: *Parent/Guardian information:*

Name _____
Address_____
City_____ Postal Code_____
Phone (H)_____(B)_____(C)_____

How did you hear about us? (Circle) Google Instagram Facebook Others
Or Who may we thank for your referral? _____

SIGNATURE ON FILE REGARDING YOUR DENTAL CLAIMS

I understand that my insurance is an agreement between my insurance company and me.
I understand that I am responsible for my balance regardless of my benefits.
I am responsible for keeping track of my annual maximums, frequency restrictions, updating and informing any changes with my insurance to Douglasdale Dental.
I authorize release of any information and the use of **Signature on File** by Douglasdale Dental relating to and the processing of my Dental Claims.
I assign dental benefit payments to be paid directly to Dr. Seama Shalchi-Moghaddam, Douglasdale Dental from my insurance.

Patient Signature (Parent or Guardian): **X** _____

CREDIT CARD INFORMATION REQUIRED

OUR OFFICE WILL ACCEPT PAYMENT FROM YOUR INSURANCE, BUT REQUIRE A CC ON FILE.
VISA/MASTERCARD #_____EXPIRY (MM/YY) _____ CCV/CVC _____
Patient balances under $100.00 will be charged to CC on file. (For balances over $100.00, our office will obtain verbal consent from cardholder before charging.)
Patient Signature (Parent or Guardian): **X** _____ Date**:** _____

PATIENT CONSENT

The undersigned hereby authorizes Doctor to take X-rays (radiographs), 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 also authorize Doctor to perform any and all forms of treatment, therapy, and medication that may be indicated in connection with patient and further authorize and consent that the Doctor choose and employ such assistance as is deemed appropriate. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient Signature (Parent or Guardian): **X** _____ Date**:** _____

YOUR MEDICAL HISTORY

General Physician's Name_____Phone_____

Approximate Date of Last Exam (if applicable) _____

Are you now under the care of a physician? ☐ Y ☐ N If yes, please explain_____

Have you been admitted to a hospital, or needed emergency care during the past 2 years? ☐ Y ☐ N

If yes, please explain_____

Are you pregnant? ☐ Y □ N | Are you nursing? ☐ Y □ N | Are you taking oral contraceptives? ☐ Y □ N

Check if you are allergic to, or have had any reaction to:

☐ Local Anesthetic
☐ Any Metal (nickel, mercury, etc.)
☐ Penicillin (or any other antibiotics)
☐ Latex Rubber
☐ Sulfa Drugs
☐ Sedatives
☐ Codeine
☐ Aspirin
☐ Other (please list) _____

Do you use tobacco? ☐ Y ☐ N Frequency? _____

Do you use illegal/controlled substances? ☐ Y ☐ N Frequency? _____

Please list all medications you are currently taking (including non-prescription)

_____
_____
_____
_____
_____

Check if you have or had:

☐ High Blood Pressure (Medicated? ☐Y☐N)
☐ Cancer (growths/tumors) (Chemo? ☐Y☐N)
☐ Rheumatic Fever
☐ Thyroid Disease/Malfunction
☐ Diabetes (Insulin? ☐Y☐N)
☐ Respiratory Problems
☐ Mitral Valve Prolapse
☐ Artificial joints/implants/valves/pacemaker
☐ Describe_____
☐ Alcohol/Substance Abuse
☐ Sexually Transmitted Disease
☐ Heart Attacked
☐ Low Blood Pressure
☐ Asthma (Inhaler? ☐Y☐N)
☐ Mouth sores (Herpes)
☐ Excessive Bleeding
☐ Nervous Problems
☐ Epilepsy/Convulsions
☐ AIDS/HIV Infection
☐ Rapid Weight Gain/Loss
☐ Hepatitis (Type_____)
☐ Psychiatric Care
☐ Stomach Problems/Ulcers
☐ Kidney Disease
☐ Hay Fever
☐ Sinus Problems
☐ Heart Murmur
☐ Heart Disease
☐ Stroke
☐ Headaches
☐ Jaundice
☐ Chest Pain
☐ Fainting
☐ Glaucoma

YOUR DENTAL HISTORY

What would you like us to do today? _____

Are you in dental discomfort today? ☐ Y □ N If yes, when did it start? _____

Approximate date of last dental care_____

Have you ever had an unpleasant dental experience or any complications following treatment?
If yes, please explain_____

Check if you have or had:	☐ Bleeding Gums	☐ Food Collecting between Teeth	☐ Orthodontic Treatment
☐ Clicking or Popping Jaw	☐ Bad Breath	☐ Loose Teeth or Broken Fillings	☐ Grinding or Clenching

SHORT NOTICE CANCELLATION & NO SHOW POLICIES

Welcome to our clinic! It is our goal to provide you and your family with the highest quality of dental care while ensuring your comfort. To keep our standard of care and customer service at a level that suits best your dental needs, we ask you to review the following guidelines:

When you book an appointment, this means we are reserving for you the **time**, the **staff**, the necessary **equipment and materials**, as well as the required **operatory space**. Our doctor, our assistant and our hygienist also take time to prepare the space prior your appointment. This also involves sterilizing and preparing any equipment and materials needed for your procedure.

There are times when our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When advanced notice of a need to reschedule or cancel an appointment is given, this time can be used to accommodate patients in need of urgent care (especially those who may be suffering or in pain).

With these considerations in mind, we **require a minimum of 48 hours notice if an appointment is to be rescheduled or cancelled.** As a *courtesy,* we will do our best to contact you before your appointment to remind you of the appointment that you have booked.

If less than the requested notice is given, a **charge of $50** will apply. Please be aware that insurance companies **DO NOT** cover fees for broken appointments. This fee would be the patient's responsibility and any future appointments will no longer be held until the fee has been paid.

In the event a patient is not providing the requested notice for a second occasion, we reserve the **right to ask the patient to find another practice**, at which point our administrative team will be happy to forward any records the new office may need.

Of course, exceptions will be made for illness or personal tragedy.

I, _____, have reviewed and understand the policies for any appointment changes and cancellations.

Patient's signature or Parent/Guardian Signature: _____

Date: _____