**NEW PATIENT INFORMATION FORM**

|  |  |
| --- | --- |
| Name : Mr./Miss/Mrs./Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **In Case Of Emergency, We Should Notify:** |
| Date of Birth (DD/MM/YY): \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ | Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name Of Family Doctor? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Home Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name Of Medical Specialist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Who Referred You To Our Office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Area Of Speciality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SECONDARY INSURANCE INFORMATION**

**PRIMARY INSURANCE INFORMATION**

Name of Insured (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth of Insured (DD/MM/YY): \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

Policy/Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certificate ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Division Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth of Insured (DD/MM/YY): \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

Policy/Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Certificate ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Division Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Secondary Insurance? No Yes

**(PLEASE FILL OUT NEXT SECTION)**

**INSURANCE ASSIGNMENT OF BENEFITS**

I would like my insurance provider to submit direct payment to Silver Maple Dental and I will pay any outstanding balances.

I would like to PAY IN FULL and have my insurance provider to submit direct payment to myself (Insured).

**ELECTRONTIC CLAIM AUTHORIZATION**

I understand that Silver Maple Dental (Dr. Nazli Sheibani Dentistry) has invested in the technology to submit my claims electronically. I authorize release, to my dental benefit carrier, information contained in claims submitted electronically.

|  |  |  |
| --- | --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**CANADA ANTI-SPAM LEGISLATION (CASL) effective July 1, 2014**

In order to comply with Canada Anti- Spam Legislation, it is mandatory that we obtain your permission in order to continue any correspondence electronically. Know that we are committed to protecting your electronic information. You can unsubscribe or “opt out” at any given time by contacting us. Our office would like to have your consent to send Email/Text appointment reminders, notifications, and occasionally surveys and important newsletters from Dr. Nazli Sheibani & Silver Maple Dental.

Yes, I consent to receiving all communication as listed above from Dr. Nazli Sheibani & Silver Maple Dental.

No, I do not wish to receive any communication as listed above from Dr. Nazli Sheibani & Silver Maple Dental.

|  |
| --- |
| Signature: |

**The following information is required to enable us to provide you with the best possible dental care. All the information is strictly privet, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.**

1. Are you currently being treated for any medical condition or have you been treated within the past year?

Yes No Not Sure/Maybe

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When was your last dental checkup? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has there been any change in your general health in the past year?

Yes No Not Sure/Maybe

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you taking any medication, non-prescription drugs or herbal supplements of any kind?

Yes No Not Sure/Maybe

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any allergies?

Yes No Not Sure/Maybe

If yes, please categories below:

1. Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Latex/rubber products \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Other (e.g. hay fever, seasonal/ environmental, food) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Have you ever had a peculiar or adverse reaction to any medicines or injections?

Yes No Not Sure/Maybe

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have or have you ever had asthma?

Yes No Not Sure/Maybe

1. Do you have or have you ever had any heart or blood pressure problems?

Yes No Not Sure/Maybe

1. Do you have or have you ever had a replacement or repair of heart valve, an infection of heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease)? Or a heart transplant?

Yes No Not Sure/Maybe

1. Do you have a prosthetic or artificial joint?

Yes No Not Sure/Maybe

1. Do you have or have you ever had any heart or blood pressure problems?

Yes No Not Sure/Maybe

1. Have you ever had hepatitis, jaundice or liver disease?

Yes No Not Sure/Maybe

1. Do you have a bleeding problem or bleeding disorder?

Yes No Not Sure/Maybe

1. Have you ever been hospitalized for any illnesses or operations?

Yes No Not Sure/Maybe

1. Do you have or have you ever had any of the following? Please check.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Chest Pain |  | Rheumatic fever |  | Pacemaker |  | Steroid therapy |  | Seizures(epilepsy) |
|  | Heart Attack |  | Mitral valve prolapse |  | Lung disease |  | Diabetes |  | Kidney disease |
|  | Heart Murmur |  | Tuberculosis |  | Stomach ulcers |  | Thyroid disease |  | Shortness of breath |
|  | Stroke,TIA |  | Cancer |  | Arthritis |  | Drug/alcohol/cannabis use or dependency |  | Osteoporosis medications (e.g. Fosamax, Actonel) |

1. Are there any conditions or disease not listed above that you have or have had?

Yes No Not Sure/Maybe

If yes please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are there any disease or medical problems that run in your family (e.g. diabetes, cancer or heart disease)?

Yes No Not Sure/Maybe

If yes, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you smoke or chew tobacco products? Yes No Not Sure/Maybe
2. Are you nervous during dental treatment? Yes No Not Sure/Maybe
3. Are you breastfeeding or pregnant? What is the expected delivery date? Yes No Not Sure/Maybe
4. Do you identify as a patient with disability)? Yes No Not Sure/Maybe

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental history questionnaire**

1. What is the reason for your visit today? Are you currently experiencing any dental problems?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been seeing a dentist regularly? Yes No

If No, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you nervous during dental visits? Yes No
2. Have you had a bad experience or complications during dental treatment? Yes No
3. When was your last dental visit? What was done at the appointment?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When did you last have dental X-rays? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever seen a dental specialist? Yes No Not Sure/Maybe
3. How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been told to take antibiotics before a dental appointment? Yes No Not Sure/Maybe
2. Do you feel that you have bad breath? Yes No Not Sure/Maybe
3. Are you happy with the appearance of your teeth? Yes No Not Sure/Maybe
4. Do you have any problems with your jaw (clicking, limited movement, pain)? Yes No Not Sure/Maybe
5. Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?

Yes No Not Sure/Maybe

**CANCELLATION / NO SHOW POLICY**

Please know that appointment times have been reserved especially for you, and any change in the schedule affects other patients. If for any reason you are unable to keep the reserved appointment time, we ask the courtesy of **48 hours’ notice** to allow us to offer the time to another patient who may be waiting for an opening. Appointments cancelled with less than **48 hours’ notice** will be subject to a cancelation fee of **$50**. In addition, No Show Appointment will also be subject to a fee of **$100**. By initialing I understand the Cancelation & No Show Policy at Silver Maple Dental. \_\_\_\_\_\_\_\_\_\_\_ (Please Initial)

**To the best of my knowledge, the above information is correct:**

|  |  |
| --- | --- |
| Patient/parent/Guardian Name Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Dentist signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |