

Clover Hills Dental
REGISTRATION FORM
(Please Print)

PATIENT INFORMATION
(or Responsible Party if under the age of 19)

Last Name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mst.	Marital Status (circle one) Single / Mar / Div / Sep / Widowed / Common law
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Name:	E-Mail Address:		Birth date: DAY / MONTH / YEAR / / <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street address: (Include apt or unit number)		Home phone no.: ()		Cell no.: ()	
City:	Province:	Postal Code:	Preferred Method of Contact: Text message via Cell / E-mail		
Social Insurance Number:	Employer / Occupation:		Employer phone no.: ()		
Referred by (please check one box): <input type="checkbox"/> Walk by <input type="checkbox"/> Staff <input type="checkbox"/> Door Hanger					
<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Newspaper Ad	<input type="checkbox"/> Postcard	<input type="checkbox"/> Website	<input type="checkbox"/> Sign	<input type="checkbox"/> Other (Please explain)
Other family members seen here:					

INSURANCE INFORMATION

Primary Holder's Name	Birth date: / /	Employer:	Insurance Company Name:
Policy Holder's Address & Phone Number (if different than above)	Relation to Insured	Certificate/ID #:	Group/Plan/ Policy #:
Secondary Holder's Name	Birth date: / /	Employer:	Insurance Company Name:
Policy Holder's Address & Phone Number (if different than above)	Relation to Insured	Certificate/ID #:	Group/Plan/Policy #:

I authorize release, to my dental benefits plan administrator and CDA net, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of service described to the named dentist. I hereby assign my benefits, payable from claims submitted electronically, to Dr Bhullar and / or Dr. Henne and authorize payment directly to him/her.

Signature of patient, parent or guardian

Date

Medical History

Date: _____ Date of Birth: _____ Medical Physician: _____

Name: _____ Preferred Name: _____ Occupation: _____

- | | | |
|---|-----|----|
| 1. Are you having pain or discomfort at this time? | YES | NO |
| 2. Do you feel nervous about having dental treatment done? | YES | NO |
| 3. Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax, or Zometa, within the past twelve years? | YES | NO |
| 4. Have you used Cocaine, Ecstasy, Marijuana or Methamphetamines? | YES | NO |
| 5. Do you smoke cigarettes or use tobacco products? | YES | NO |
| 6. Do you have or have had any of the following (please circle) | | |

****This information is used to assess the impact your health history may have on any dental treatment**

High Blood Pressure	Hepatitis	Bleeding Disorder	Heart Attack	Colonary Bypass
Jaundice	Glaucoma	Arrhythmias	Liver Disorders	Chemical Dependency
Pacemaker	Anemia	Alcoholism	Stroke	Respiratory Problems
Heart Murmur	Heart Defect	Diabetes	Kidney Problems	Osteoporosis
Epilepsy	Venereal Disease	Mitral Valve Prolapse	Arthritis	Rheumatic Fever
Tuberculosis	Herpes	Blood Transfusion	Cancer	Artificial Joint
AIDS/ HIV Positive	Psychiatric Treatment	Hemophilia	Ulcers	Heart Valve Replacement

7. Have you had any other serious illness not listed above? Yes No
 If yes, please describe. _____

8. Do you have any allergies sensitivities to any of the following:

Penicillin	Erythromycin	Tetracycline	Sulfa	Demerol	Aspirin	Valium
Percoden	Codeine	Latex				

9. Are you taking any drugs or medications now? If YES please list ALL herbal remedies and over the counter medications. _____

- | | | |
|--|-----|----|
| 10. Have you ever had any unfavorable reactions to dental treatment?
If yes please explain. _____ | YES | NO |
| 11. Do you premedicate with antibiotics prior to ALL dental appointments?
If yes, please explain. _____ | YES | NO |
| 12. Have you ever had excessive bleeding requiring special treatment?
If yes, please explain. _____ | YES | NO |
| 13. FEMALE PATIENTS: Are you trying to conceive, pregnant or nursing?
Do you take birth control Pills? | YES | NO |
| | YES | NO |

Please read and sign below:

I authorize the dentists and the professional staff of Clover Hills Dental to consult with my physician to seek clarification on the effect of my previous or past medical or dental condition. I also authorize and consent to perform tests/x-rays and treatment as required. To avoid any misunderstanding regarding dental insurance, we want our patients to know that we are providing you with a service and billing your insurance provider to the best of our knowledge, however any unpaid portions that insurance was expected to pay will be your responsibility.

Date: _____ Printed Name: _____ Signature: _____

Staff Use Only: Referral Source: _____



Clover Hills Dental

Family & Cosmetic Dentistry

It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. To keep our standard care to a level which best serves your dental needs, we ask that you observe the following.

Cancellation Policy

Our clinic requires a minimum of 2 business days notice if an appointment must be cancelled. A short notice cancelled appointment *can adversely affect many other patients specially those who are suffering or in pain. If less than 2 business days notice is given to cancel an appointment or no notice is given a fee of \$90.30 will be assessed.*

In the event that a patient does not “show up” on a second occasion, the practice policy is to ask that patient to find a new different practice at which point our administrative staff will be happy to transfer the patient’s records with a letter explaining why the transfer is being made. *Please note insurance company’s do not cover any fees associated with missed or cancelled appointments; therefore payment is made the patient’s responsibility prior to re-scheduling.*

Exceptions will be made for illness or personal tragedy.

Payment Policy

Payment is due upon completion of treatment.

*Patients with Insurance benefits: *** please read below****

Dental insurance is an agreement between YOUR EMPLOYER, YOU and an INSURANCE COMPANY. We work with most insurance companies and always try to maximize your coverage through meticulous detailing of procedures and interaction with your insurer. Due to many privacy acts that have evolved through the years, most insurance companies will only release very limited information. Insurance companies will not give us information on services billed by any other dental office. *We will do our best to provide you with an accurate estimate; however you will be responsible for any balance not paid by insurance. Initials _____.*

We at Clover Hills Dental look forward to taking care of your oral health needs and welcome you to our team of professionals.

I have read the above office policy of Clover Hills Dental and understand my responsibilities as a patient or a responsible party.

Print Name

Signature

Date