Sky Harbour Dental

12 Sky Harbour Drive Unit 2, Brampton, ON, L6Y0V7
Phone: (289) 801-3623
Fax: (289) 236-0252
Email: info@skyharbourdental.ca

PERSONAL INFORMATION

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Last name _____ First name _____ Date of Birth MM/DD/YYYY Gender: M❑ F❑

Address_____ City_____ Postal Code_____

Phone (Res)_____ Phone (Bus)_____ Phone (Cell) _____

Occupation _____ Employer_____ Address_____

Family Physician_____ Phone (Bus) _____

Date of Last Exam MM/DD/YYYY) Marital Status_____ Health Card #_____

Email_____

Name of Spouse, Parent, or Guardian_____

Occupation _____ Employer_____ Address_____
Phone (Res)_____ Phone (Bus)_____ Phone (Cell) _____

Whom may we thank for referring you to our practice?

❑ Another Patient_____ ❑ Doctor_____
❑ Hygienist_____ ❑ Staff_____
❑ Other_____

INSURANCE INFORMATION

Do you have dental insurance? Yes ❑ No ❑

Name of Insured_____ Insured Date of Birth MM/DD/YYYY

Insurance Company_____ Group # _____ _____ID #_____

Driver's License #_____ Credit Card #_____ Exp MM/YYYY

This information is collected to verify identity and settle any account balances not covered by insurance.

SECONDARY INSURANCE INFORMATION

Do you also fall into another family members dental insurance? Yes ❑ No ❑

Name of Insured_____ Insured Date of Birth MM/DD/YYYY

Insurance Company_____ Group # _____ _____ID #_____

Driver's License #_____ Credit Card #_____ Exp MM/YYYY

This information is collected to verify identity and settle any account balances not covered by insurance.

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HEALTH INFORMATION

Have you ever had any of the following? Please check those that apply:

- ❑ AIDS/HIV
- ❑ Allergies
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy/Convulsions
- ❑ Emphysema
- ❑ Excessive Bleeding
- ❑ Fainting/Seizures
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Problems
- ❑ Heart Attack
- ❑ Heart Murmur F/O
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Latex Allergy
- ❑ Liver Disease
- ❑ Leukemia
- ❑ Mental Health Disorders
- ❑ Mitral Valve Disorder
- ❑ Nervous Disorder
- ❑ Pacemaker
- ❑ Pregnancy Due MM/DD/YYYY
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Sinus Problems
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tumors
- ❑ Thyroid Problem
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Codeine Allergy
- ❑ Penicillin Allergy

Other:

- ❑ Complications after dental treatment
- ❑ Need for admission to a Hospital/Emergency
- ❑ Under the care of a physician
- ❑ Other health concerns

DENTAL INFORMATION

Have you ever had any of the following? Please check those that apply:

- ❑ Bad Breath
- ❑ Bad Experience
- ❑ Bleeding Gums
- ❑ Blisters in Mouth
- ❑ Burning Sensation
- ❑ Chew on One Side
- ❑ Cigarette Smoking
- ❑ Clicking Jaw
- ❑ Crowns/Bridges
- ❑ Dry Mouth
- ❑ Extractions
- ❑ Fillings
- ❑ Fingernail Biting
- ❑ Food trap in Teeth
- ❑ Foreign Objects
- ❑ Grinding Teeth
- ❑ Gums Swollen/Bleeding
- ❑ Jaw Pain
- ❑ Lip/Cheek Biting
- ❑ Local Anesthetic Reaction
- ❑ Loose/Broken Teeth
- ❑ Mouth Breathing
- ❑ Mouth Pain
- ❑ Orthodontic Treatment
- ❑ Pain Around Ear
- ❑ Periodontal Treatment
- ❑ Removable Denture
- ❑ Root Canal Therapy
- ❑ Strong Gag Reflex
- ❑ Sensitivity to Cold
- ❑ Sensitivity to Hot
- ❑ Sensitivity to Sweets
- ❑ Sensitivity to Biting
- ❑ Sores/Growths in Mouth
- ❑ Syncope (Fainting)
- ❑ Any other conditions

Reason for today's visit: _____
Former Dentist: _____ City: _____ Prov: _____
Date of last dental visit: _____ Date of last dental x-rays: _____
How often do you brush: _____ Floss: _____

MEDICATIONS

List of medications you are currently taking:

_____ _____ _____

_____ _____ _____

Pharmacy_____ City/Prov_____ Phone_____

AUTHORIZATION

I have read and answered the questions to the best of my knowledge and understand that I am financially responsible for all charges whether or not paid by insurance. I agree **Sky Harbour Dental** can collect, use and disclose personal information about myself or my dependents as set out above in the information about the office's privacy policies. I further agree to receive electronic messages, including text messages, in regards to communicating appointments, requests, information, products, promotions, company news and updates which can be withdrawn at any time.

_____ Signature

_____ Date MM/DD/YYYY

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FINANCIAL POLICY

Our fees are based on the quality of the products and materials we use and our experience in performing your scheduled treatment. Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. We also realize that every patient's financial situation is different.

Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

- **For patients who have insurance**, the entire estimated patient portion is due at the time of service. We ask that you read and be aware of your insurance benefits, exclusions and frequency limitations. Every plan is different, and changes do occur frequently. We will perform an initial insurance verification and do our best to provide you an estimate of your co-pay prior to your appointment. If you are covered by 2 insurance companies, you need to be aware of a duplication clause and verify whether or not your secondary insurance has standard coordination of benefits or not. This may limit your secondary insurance payment.

- As a courtesy, we will gladly process your insurance claims and estimate the amount not covered by your insurance. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage.

- 48-hour notice is required for any cancellation or rescheduled appointment. For missed appointments, we reserve the right to charge a missed appointment **$50 fee**.

My signature below certifies that I have read and understand the terms of the Financial and 48-hour cancellation policy listed above.

Printed Name: _____

Signed: _____ Date: _____
Patient or Legal Guardian's Signature *MM/DD/YYYY*

General Consent statement: I certify that I have read, understood and accurately completed the personal, medical, and dental histories, to the best of my knowledge, and have not knowingly omitted any information. I authorize the dentist to perform necessary diagnostic procedures and treatments to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

I give express consent to receiving commercial electronic messages from **Sky Harbour Dental**. I understand my contact information will be protected and used only for communicating regarding my or my dependent's care.

I agree that **Sky Harbour Dental** has obtained informed consent from me with respect to the collection, use and disclosure of my personal information. Upon my request, I have been provided with a copy of the Privacy Code and agree that personal information may be collected, used and disclosed as set out in the Code and is in accordance with the Personal Health Information Protection Act, 2004.

I am aware that missing an appointment or failing to give two business day's notice for a cancellation may result in a cancellation fee.

Consent to Electronic Submission of Insurance Claims: I authorize release, to my benefits plan administer and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of service described to **Sky Harbour Dental**. This authorization shall continue until the undersigned revokes the same.

Patient/Parent or Guardian Signature: _____ Date: _____