Winchester Dental
16 Winchester Rd. Unit #5, Brooklin, ON, L1M 1B3| Tel: 905-425-4205 Fax: 905-425-4206

New Patient Registration

Salutation: Mr. Mrs. Ms. Miss/Master. Dr. Gender: Female Male
Full Name:_____ Preferred Name:_____
Date of Birth:_____
Address:_____ City:_____ Postal Code:_____
Home #:_____ Work#:_____ ext._____ Cell#:_____
Email Address:_____
Best Method to Contact: Email Home# Cell#

Emergency Contact: Who should we call, in case of an emergency?
Name:_____ Relationship to you:_____
Home #:_____ Work #:_____ Cell#:_____

Medical History: Have you ever had any of the following? Please circle if applicable.

AIDS/HIV
Allergy to: _____
Arthritis
Artificial Joints
Asthma
Blood Disorder: _____
Cancer
Diabetes Type 1__ Type 2__
Dizziness
Epilepsy
Excessive Bleeding
Fainting
Glaucoma
Head Injuries
Heart Disease
Heart Murmur
Mitral Valve Prolapse
Migraines
Blood Pressure High__ Low__
Jaundice
Kidney Disorder
Liver Disorder
Nervous System Disorder
Mental Disorder
Pacemaker
Radiation Treatment
Respiratory Problems
Sinus Problems
Smoking
Stomach Problems
Stroke
Thyroid Disorder
Tuberculosis
Ulcers
Women's Use: Are you currently Pregnant? Yes___ No___
Do you require Pre Med? Yes__ No__

Additional Notes Regarding Health:_____

Please list your regular medications:_____

Have you been hospitalized or required emergency medical care in the last two years? No Yes , provide details below

_____

Name of Physician: _____ Tel #:_____

Dental History and Concerns: Mark the areas that apply, and if desired, use the lines to provide additional details.

When was your last dental visit:_____ Name of Dentist:_____

What did you like about your previous dental office?_____

Anything you disliked about your previous dental office?_____

Do your gums bleed at all when you brush your teeth? Yes or No_____

Do you experience a bad taste or odour when you brush your teeth? Yes or No_____

Are any of your teeth sensitive to hot or cold? Yes or No_____

Are any of your teeth sore to chew on? Yes or No_____

Does your jaw click, crack or pop? Yes or No_____

Do you want whiter teeth? Yes or No_____

What are your goals for your visit today?_____

Insurance Coverage

Primary Insurance

Name of Insured Holder:_____

Male Female Date of Birth:_____

Employer Name:_____

Policy/Plan/Contract #:_____

ID/Certificate #:_____

Secondary Insurance

Name of Insured Holder:_____

Male Female Date of Birth:_____

Employer Name:_____

Policy/Plan/Contract #:_____

ID/Certificate #:_____

Financial Responsibility: I am responsible for my financial account **OR** The following person is responsible for my account**:**

Name:_____ Relationship to you:_____

Address:_____ City:_____ Postal Code:_____

Home #:_____ Cell #:_____ Email:_____

Appointment Cancellations

If I need to change or cancel an appointment, I will provide 2 business day's notice (unless a grave emergency occurs). I understand that without 2 business day's notice, a $25.00 charge may apply.

Please initial to signify that I understand this policy: _____

How did you hear about us?

_____

To the best of my knowledge, all the information I have provided is accurate and complete.

_____ _____

Signature of Patient or Guarantor of Payments Date

Insurance & Payment Agreement

As your dental health care providers, our job is to assess your oral condition and advise you of the health of your mouth or of any decay, infections, tissue damage, bone loss or other conditions you may have.

Just like any other doctor, we are obligated to treat all patients the same**. We advise you of treatment options based on your conditions, regardless of whether or not you have insurance or what it may or may not cover.** Insurance plans are ***not*** designed to meet all individual treatment needs. You can choose to proceed or decline treatment. If you have the benefit of some insurance coverage, **it is your responsibility to know what is and isn't covered**. We will gladly submit an estimate to your insurance coverage for you.

Please choose your preferred method of payment for your dental services:

- ☐ Option 1. **Payment will be made in cash/debit/credit-** I do not have insurance
- ☐ Option 2. **Bill my insurance directly-** I have insurance, please process to my insurance (s) company, payment will be paid directly to Winchester Dental from your insurance, any remaining difference not covered by my insurance is my responsibility to pay
- ☐ Option 3. **I will pay in full for my appointment, Winchester Dental will send through the claim to my insurance for me to receive my payment.** You have coverage with a non-assignment insurance policy, or you would rather clear your account and receive payment from your insurance directly to you.

Please note, any balances not paid by your insurance company after 6 months will be invoiced to you. Insurance companies consider health care providers third party and may not release all information to us. Your cooperation is needed in order to receive payment in some cases.

If you would like to leave a credit card on file to clear any balances not paid by your insurance please fill out the following:

Credit Card #:_____ **Expiry Date**:_____

Name on Card: _____ **CSV**:_____

I hereby agree to the payment choice I have made with Winchester Dental.

Patient Name: _____

Patient Signature: _____**Date**:_____