

Welcome to:

Patient Contact Information

Mr Mrs Ms Miss Dr First Name: _____ Last Name: _____
Preferred Name: _____ Date of Birth: _____ (DD/MM/YY) Male Female
Address: _____ Apt/Unit #: _____
City: _____ Province: _____ Postal Code: _____
Home Telephone Number: _____
May we contact you at your workplace? Yes No Work Number: _____ ext. _____
May we contact you on your cellular phone? Yes No Cell Number: _____
May we contact you by e-mail? Yes No E-mail address: _____
Employer: _____ Position: _____
Driver's Licence #: _____
Marital Status: Single Married/Common Law Other
Best way to contact you: Home# Work# E-mail Cell
Best time to contact you: Morning Afternoon Evening
In case of an emergency - Please notify _____ Phone Number: _____

Referral Information

How did you hear about us? (Check all that apply)
Internet
Phone Book
Word of Mouth
Name of Person:
Other (please specify): _____

Insurance Information

Primary insurance Company Information
Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
Insurance Policy Holder: Self Parent/Guardian Other _____
Policy Holder Contact Phone Number: _____ (if different form above)
Group Policy /Plan Number: _____ I.D./Certificate Number: _____ Employer's Name: _____
Insurance Company Name: _____

Secondary Insurance Company Information
Name of Insurance Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)
Insurance Policy Holder: Self Parent/Guardian Other _____
Policy Holder Contact Phone Number: _____ (if different form above)
Group Policy /Plan Number: _____ I.D./Certificate Number: _____ Employer's Name: _____
Insurance Company Name: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Drs. Snider & Margolian all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Dental History

Please check any of the following problems that may apply to you.

- | | | | |
|--|--------------------------|---------------------------------------|--------------------------|
| Sensitivity (hot, cold and/or sweet) | <input type="checkbox"/> | Grinding or clenching teeth | <input type="checkbox"/> |
| Tooth pain or discomfort while chewing | <input type="checkbox"/> | Bleeding, swollen or irritated gums | <input type="checkbox"/> |
| Headaches, earaches or neck pain | <input type="checkbox"/> | Loose, tipped or shifting teeth | <input type="checkbox"/> |
| Jaw joint pain (clicking/cracking) | <input type="checkbox"/> | Bad breath or bad taste in your mouth | <input type="checkbox"/> |
| Teeth or fillings breaking | <input type="checkbox"/> | | |

Do you have or have you had any of the following?

- | | | | |
|------------------|--------------------------|------------------------------|--------------------------|
| Dentures (Full) | <input type="checkbox"/> | Braces | <input type="checkbox"/> |
| Partial dentures | <input type="checkbox"/> | Periodontal (gum) treatments | <input type="checkbox"/> |

Please share the following dates:

Your last dental cleaning ____ / ____
Your last oral cancer screening ____ / ____

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes No

Do you smoke or use chewing tobacco? Yes No

If yes, how often? _____ For how long? _____

If you could change your smile, you would..

- | | |
|--|--------------------------|
| Make your teeth brighter | <input type="checkbox"/> |
| Make your teeth straighter | <input type="checkbox"/> |
| Close spaces | <input type="checkbox"/> |
| Replace metal fillings with natural, tooth coloured fillings | <input type="checkbox"/> |
| Repair chipped teeth | <input type="checkbox"/> |
| Replace missing teeth | <input type="checkbox"/> |
| Replace old crowns that don't match | <input type="checkbox"/> |
| Have a smile makeover | <input type="checkbox"/> |

On a scale of 1 to 10, with 10 being the highest rating...

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? _____

What, if anything, in the past has kept you from having dental treatment? _____

What, is the most important thing to you about your future smile and dental health? _____

What, is the most important thing to you about your visit today? _____

Medical History

Please check any of the following that apply to you:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Allergies, seasonal | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HPV | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Jaw joint pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Snoring/Sleep apnea |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Heart conditions | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart lesions, congenital | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Nervousness/Depression | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Pregnant currently | <input type="checkbox"/> Venereal diseases |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Radiation (head/neck) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory problems | |

Do you have any of the following allergies?

- | | | | |
|---------------------------------------|--|---|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitrous oxide | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulpha |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Valium | <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Percodan | <input type="checkbox"/> Penicillin | |

Have you ever had a joint replacement? Yes No If yes, when? _____

Has your physician ever told you to take antibiotics prior to dental procedures? Yes No
If so, why? _____

Have you ever experienced complications following a medical or dental procedure? Yes No
If yes, please describe. _____

Is there anything else you think we should know regarding your medical history? Yes No
If yes, please describe. _____

Are you currently under a physician's care? Yes No
If yes, what for? _____

Are you taking any medications? Yes No
If yes, please specify _____

Family Physician's Name: _____ Physician's Phone Number: _____

Medical History

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. If required, I consent to my physician being contacted regarding any specific medical questions. I authorize the dentist and his staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care.

Date: _____

Signature: _____

Please read our office Payment Options below and indicate your preference.

At Drs. Snider & Margolian we would like to make your visit as stress-free and effortless as possible. In order to provide this service to you we ask that you keep a credit card on file. We assure you our office records are secure and private.

This benefits you by allowing us to bill your insurance for services rendered and you do not require full payment on the date of service. We will do our best to maximize your benefits, but the insurance company will not guarantee any payments until they are received. Make sure to keep current with your own personal insurance policy as we do not have access to this information. Upon receiving the insurance payment we will then debit your credit card for any small remaining balance. This benefits you, as you will not have to make a special trip to our office to make payment on your account or mail in payment.

Other patients prefer to not keep a credit card on file and pay in full at time of visit and have insurance benefits sent directly to them. We will be happy to submit insurance forms on your behalf for dental benefits. Please let us know what method of payment you prefer by filling out the option pertinent to you.

Option One: Dental Insurance with credit card on file

Name on Card: _____

Card Number: _____

Billing Address: _____

Type of Credit Card: Visa _____ or MasterCard _____

Expiration Date: _____ Security Code On Back Of Card: _____

Signature of Cardholder: _____

*Please note we will send a copy of your receipt for any transaction that applies. Thank you.

Option Two: Dental Insurance payment is sent directly to my home; therefore, I will pay after each appointment by _____.
(debit, interac, mastercard, visa)

Option Three: I have no Dental Insurance and will be paying by _____ after my appointment(s).
(debit, interac, mastercard, visa)

Patient Signature: _____

Date: _____