Welcome to:

DR. SHANE SNIDER
DENTISTRY

5959 Anderson Street
Brooklin ON - L1M 2E9
905-655-6255

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

DRS. SNIDER & MARGOLIAN DENTISTRY

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

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

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

Dentures (Full)	☐	Braces	☐
Partial dentures	☐	Periodontal (gum) treatments	☐

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	☐
Make your teeth straighter	☐
Close spaces	☐
Replace metal fillings with natural, tooth coloured fillings	☐
Repair chipped teeth	☐
Replace missing teeth	☐
Replace old crowns that don't match	☐
Have a smile makeover	☐

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

DRS. SNIDER & MARGOLIAN DENTISTRY

Please check any of the following that apply to you:

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

Do you have any of the following allergies?

- ☐ *Aspirin*
- ☐ *Codeine*
- ☐ *Erythromycin*
- ☐ *Nitrous oxide*
- ☐ *Valium*
- ☐ *Percodan*
- ☐ *Latex*
- ☐ *Local anesthetic*
- ☐ *Penicillin*
- ☐ *Sulpha*
- ☐ *Other* _____

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 talking 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: _____

DRS. SNIDER & MARGOLIAN DENTISTRY

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:_____