PORTRAIT DENTAL

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NEW PATIENT PACKAGE

Please complete this form in its entirety and to the best of your ability. Please complete electronically and/or print.

First Name _____ **Last Name** _____ **Preferred Name** _____

Date of Birth (D) _ _ /(M) _ _ / _ _ _ _ **Address** _____

City/Town _____ **Province** _____ **Postal Code** _____

Home Phone # _____ **Cell Phone #** _____ **Email** _____

Gender ☐ Male / Female ☐

Emergency Contact (Name / Phone #) _____ **Relationship** _____

HOW DID YOU HEAR ABOUT US?

☐ Our webpage (Google)	☐ Radio Ad	☐ Yellow Pages (Print)
☐ Social Media (Facebook/Instagram)	☐ Newspaper Ad	☐ Yellow Pages (Online)
☐ Word of Mouth	☐ Community Event	☐ Other _____

If you were referred by word of mouth, whom may we thank for the referral? _____

PRIMARY INSURANCE INFORMATION (IF APPLICABLE):

Employer _____ **Work Phone #** _____

Account Holder's Name _____ **Holder's Date of Birth (D)** _ _ /(M) _ _ / _ _ _ _

Relation to Holder: ☐ Spouse ☐ Child ☐ Common-law ☐ Other _____

Insurance Carrier _____ **Policy/Group #** _____ **ID or Certificate #** _____

SECONDARY INSURANCE INFORMATION (IF APPLICABLE):

Employer _____ **Work Phone #** _____

Account Holder's Name _____ **Holder's Date of Birth (D)** _ _ /(M) _ _ / _ _ _ _

Relation to Holder: ☐ Spouse ☐ Child ☐ Common-law ☐ Other _____

Insurance Carrier _____ **Policy/Group #** _____ **ID or Certificate #** _____

MEDICAL HISTORY

Are you under the care of a physician? ☐ Yes ☐ No

Physician's Name _____ **Phone #** _____ **Year of Last Complete Exam** _____

If yes, why?

MEDICAL HISTORY (Continued)

Are you currently taking any medications (including non-prescription/herbal)?	Yes ☐	No ☐
If yes, list:		
Do you have allergies (medications/latex products etc.)?	Yes ☐	No ☐
If yes, list:		
Have you ever had an adverse reaction to any injections?	Yes ☐	No ☐
If yes, why/type of reaction?		
Have you ever had any serious illness or hospitalization?	Yes ☐	No ☐
If yes, why?		
Have you had a serious injury to your head, neck or face?	Yes ☐	No ☐
If yes, where?		
Have you ever had a heart murmur/endocarditis/rheumatic fever/mitral valve prolapses?	Yes ☐	No ☐
Do you have any artificial joints or artificial heart valve?	Yes ☐	No ☐
If yes, when was it placed?		
Have you had heart problems or a cardiac stent?	Yes ☐	No ☐
If yes, when?		
Have you ever had to take antibiotics one hour before your dental visits?	Yes ☐	No ☐
If yes, which antibiotics?		
Do you have a pacemaker or implantable defibrillator?	Yes ☐	No ☐
Do you have or ever had any heart/blood pressure problems?	Yes ☐	No ☐
High or low and how high?		
Are you taking blood thinners?	Yes ☐	No ☐
If yes, which ones?		
Have you ever had prolonged bleeding that won't stop?	Yes ☐	No ☐
Do you have any conditions that could compromise your immune system (AIDS, HIV)?	Yes ☐	No ☐
If yes, please elaborate.		
Are you taking weight management medications?	Yes ☐	No ☐
If yes, list:		
Do you use any tobacco products?	Yes ☐	No ☐
If yes, what and how much? And since when?		

FEMALE PATIENTS ONLY

Are you taking contraceptives?	Yes ☐	No ☐
Are you pregnant?	Yes ☐	No ☐
If yes, how far along? Expected delivery date?		
Are you currently nursing?	Yes ☐	No ☐

MEDICAL HISTORY (continued)

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

☐ Angina/Heart Attack	☐ Liver Disease	☐ Stomach Ulcers	☐ Emphysema
☐ Stroke	☐ Hepatitis A, B, C	☐ Arthritis	☐ Cancer
☐ Asthma	☐ Thyroid Disease	☐ Epilepsy/Seizures	☐ Blood Disorders
☐ Tuberculosis	☐ Hormone Deficiency	☐ Fainting Spells	☐ Sinus Problems
☐ Kidney Disease	☐ Diabetes	☐ Organ Transplants	☐ Steroid Therapy
☐ Alcohol/Drug Dependency	☐ Viral Infections/Herpes/Cold Sores		
☐ Congenital Heart Disease	☐ Depression/Psychiatric illnesses/Anxiety/Nervous Disorder		

Are there any other medical conditions not listed above that you think we should know about? ☐ Yes ☐ No

If yes, please describe:

DENTAL HISTORY

Who was your previous dentist? _____ **Where was that office located?** _____

When was your last dental exam? _____ **Last cleaning?** _____

How often do you visit the dentist? ☐ 6 months ☐ Yearly ☐ Other _____

Have you had X-rays in the last year? ☐ Yes / No ☐ **If yes, would you like us to request them?** ☐ Yes / No ☐

How often do you brush your teeth? _____ **Floss** _____

Do your gums bleed when you brush? ☐ Yes / No ☐

Are any of your teeth sensitive to: ☐ Cold/Heat ☐ Sweets ☐ Chewing ☐ Other _____ ☐ Not Sensitive

Do you have pain in your jaw joints or suffer from migraine headaches? ☐ Yes / No ☐

Does your jaw crack or pop when you open widely? ☐ Yes / No ☐

Have you ever had abnormal bleeding with a previous extraction? ☐ Yes / No ☐ ☐ Not Sure

Do you have dental anxiety? ☐ Yes / No ☐

Have you had any other problems with dental treatment?

What can we do to surpass your expectations at our clinic?

Reason for your visit? Please check all that apply:

- ☐ Regular checkup/cleaning
- ☐ I'm grinding or clenching my teeth
- ☐ My teeth are misaligned
- ☐ I want to replace my missing teeth
- ☐ My gums are sore or bleed
- ☐ I have a toothache
- ☐ I want cosmetics/whitening
- ☐ My jaw is sore or swollen
- ☐ I think I have a cavity
- ☐ I need a sports mouth guard

CERTIFICATION OF MEDICAL AND DENTAL HISTORY

I certify that I have provided an accurate and complete medical and dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions about my medical history. I understand it is my responsibility to inform this office of changes to my medical history when they occur.

Patient (or Parent/Guardian) _____ **Signature** _____

Date _____ **Witness** _____

INSURANCE PAYMENT OPTIONS – PLEASE CHOOSE EITHER OPTION #1 OR OPTIONS #2

☐ **OPTION #1 – Off Assignment**

I agree to pay in full for treatment and get reimbursed directly by my insurance company.

Patient (or Parent/Guardian) Signature _____ **Date** _____

OR

☐ **OPTION #2 – On Assignment**

- Once we receive payment from your insurance company, there may be a credit or debit on your account. We periodically rebalance all accounts to zero, therefore we require a credit card to be left on file.
- Insurance Companies are legally obligated to ONLY release information and send correspondence to the subscriber, making it difficult for us to assist you with your Insurance Benefits. If you choose to go "On Assignment", we require you to complete and maintain an updated Privacy & Consent Form with our office so we may communicate directly with insurance company regarding your benefits.

If you have selected this option, please provide your credit card information on the following page.

OPTION #2 – ON ASSIGNMENT: CREDIT CARD INFORMATION

As evidenced by my signature below, I authorize Portrait Dental to keep my signature and credit card number on file to issue any credit/debit memos, as well as outstanding payments, to my credit card account for the undernoted patient. I agree that it is my responsibility to follow up on the account status after 30 days of my visit. In the event that my credit card is declined, I agree to make alternate payment arrangements within 14 days, otherwise I consent to interest being charged on any outstanding amount at a rate of 1.5% per month (compounded monthly).

Patient's Name _____

Cardholder Signature _____ **Date** _____

Cardholder Name _____ **Credit Card #** _____

Credit Card ☐ Visa / MasterCard ☐ **Expiry Date (M)** _ _ / **(Y)** _ _ **CVV2 #** _ _ _

(three numbers on the back of card)