STRAWBERRY HILL FAMILY DENTAL

604 594 1551
info@strawberryhilldental.com
7180 120 St, Surrey, BC V3W 3M8

Patient Info

Name: _____ (Last) _____ (First) Birthdate: (MM/DD/YYYY) _____ Sex: ☐ Male ☐ Female ☐ Prefer not to say

Address: _____ City: _____ Province: _____ Postal Code: _____

Email: _____ Home Phone: _____ Cell Phone: _____ Preferred Method of Contact: ☐ Phone ☐ Text ☐ Email

Emergency Contact Name: _____ (Last) _____ (First) Relationship to Patient: _____

Emergency Contact Number: _____ How did you hear about us? _____

Physician Name: _____ Physician Number: _____ Last physician visit (MM/YYYY): _____

Guardian Info

If you are registering for your child, please fill out the following information.

Guardian Name: _____ Relationship: _____ Phone: _____ Email: _____

Medical Information

Have you had a recent exposure to any communicable infectious diseases? (Measles, Chicken Pox or Tuberculosis)	Yes	No
Do you require premedication prior to hygiene (cleaning) appointments or dental treatment? If yes please be sure to take your premedication prior to your appointment.	Yes	No
Have you ever had any major surgeries? If yes, please explain:	Yes	No
Are you taking any medications (including birth control, vitamins, etc.) If yes, please explain	Yes	No
Are you pregnant or nursing, or a possibility you could be pregnant?	Yes	No

Please circle any of the following below that you have ever had a bad reaction or known allergies to:

Local anesthetics Latex Codeine NSAID Penicillin Barbiturates Aspirin (ASA) Metal Iodine Other: _____

Have you had or do you have any of the following?

☐ Anemia	☐ Stroke	☐ Osteoporosis
☐ Heart Disease	☐ Artificial Heart Valve	☐ Congenita Heart Defects
☐ Rheumatic Heart Disease	☐ Angina	☐ Heart Attack
☐ Chest Pain	☐ Pacemaker	☐ Tuberculosis
☐ Asthma	☐ Cancer	☐ Emphysema
☐ Pneumonia	☐ Radiation Therapy	☐ Thyroid Disease
☐ Chemotherapy	☐ Mental Illness	☐ Liver Disease
☐ Drug/Alcohol Dependency	☐ Syncope/Fainting	☐ HIV
☐ Heart Murmur	☐ High Blood Pressure	☐ Rheumatoid Arthritis
☐ Eye Disorders	☐ Epilepsy	☐ Seizures
☐ Malignant Hyperthermia	☐ Kidney Disease	☐ Diabetes
☐ Smoker	☐ Pins, Plates, Replacement Joints	☐ Pleurisy

Have you had or do you have any medical condition not listed? Yes No
If yes, please list the condition

_____

Dental Information

Last dental check-up/cleaning? _____ Brushing Frequency? _____

How often do you visit the dentist? _____ Flossing Frequency? _____

Do you have any problems that require immediate attention? If yes, please explain: _____ Yes No

Do you clench or grind your teeth? Yes No

Have you had any orthodontic treatment (braces or Invisalign)? Yes No

Are you interested in straightening your teeth? Yes No

Have you ever considered teeth whitening, crowns, or veneers? Yes No

Please add anything you feel is important that we should know about:

_____

Insurance Information

Policy Holder's Name _____

Policy Holder's DOB _____

Insurance Company/Carrier _____

Group or Policy Number _____

ID/ Certificate No. _____

Employer Name _____

Employer's Phone _____

Additional Insurance Information

Policy Holder's Name _____

Policy Holder's DOB _____

Insurance Company/Carrier _____

Group or Policy Number _____

ID/ Certificate No. _____

Employer Name _____

Employer's Phone _____

Consent for Release, Assignment of Benefits, Financial Agreement and Cancellation Policy

I authorize the release of my electronic claims information to my dental benefits plan administrator and the CDA. I also authorize the sharing of information related to my coverage to my named dentist. This authorization will remain in effect until revoked.

I assign my benefits payable from electronically submitted claims to the dental office and authorize direct payment to them. This authorization will remain in effect until revoked.

Please note that insurance coverage only pays a percentage of the total fee, so we require a credit card number to accept assignment. Our office will contact you for authorization to use this credit card to pay the remaining balance not covered by your insurance provider.

I understand that anything not covered by my dental insurance is my full responsibility to pay. We may help to provide the most accurate estimate possible, but it is ultimately the patients responsibility to know what their insurance coverage details are.

We will make every effort to obtain your records and x-rays from your previous dental office, but delays can occur. If we do not have the appropriate x-rays or if they are outdated (usually over 1 year old), we may need to take new ones at your appointment. Please contact our office at least 1 day prior to your appointment to verify that we have received your records from your previous office. While we will assist you in this process, it is ultimately the patient's responsibility to ensure records are transferred.

Note that in some cases, x-rays from other offices may not be of sufficient quality. Our dentist may need to take new x-rays for a proper exam, free of charge if the previous x-rays are not outdated.

I understand that your office requires **48 hours notice** prior to cancelling or rescheduling appointments. Failure to do so or not showing up may result in a **$150** fee. Our office will send email and text appointment reminders as a courtesy. If you prefer not to receive these reminders, please inform our reception.

☐ **I acknowledge that I have read, understand, and agree that I will be responsible for the difference not covered by my dental insurance, and agree to the policies and procedures defined in this new patient form that I received.**

_____ _____

Signature of Patient, or Guardian Date (MM/DD/YYYY)