GREAT SLAVE DENTAL CLINIC

NAME:_____ HOME PHONE NO._____
DATE OF BIRTH:_____ OFFICE PHONE NO._____
MAILING ADDRESS:_____ PERSON RESPONSIBLE FOR ACCOUNT_____
_____ HIS/HER EMPLOYER_____
EMAIL ADDRESS:_____

HEALTH QUESTIONNAIRE

Certain information is necessary for proper diagnosis and treatment. All information is held in strict confidence. Please answer to the best of your knowledge the questions listed below. If there are any important areas of your past DENTAL or MEDICAL history, please advise your dentist.

1. When was your last dental visit (year)?_____
2. Name and phone number of Family Physician _____

	Please Check YES	NO
3. Have you ever had an unusual reaction to any drugs or medicine (i.e. Penicillin or Aspirin)?	☐	☐
4. Are you aware of any other allergies? Please List_____	☐	☐
5. Any history of joint prostheses procedures in the past 2 years?	☐	☐
6. Are you taking any medicine or tablets now? Please List_____	☐	☐

7. Have you had:

	YES	NO
Heart or chest disorder	☐	☐
High blood pressure	☐	☐
Rheumatic fever or heart murmur	☐	☐
Kidney trouble	☐	☐
Liver trouble	☐	☐
Diabetes	☐	☐
Epilepsy	☐	☐
Thyroid trouble	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
New cough or shortness of breath	☐	☐
New fever or chills in the last 24 hours	☐	☐
New undiagnosed rash, lesion, or break in skin Anemia	☐	☐

Any others (please list)

_____

_____

Continued on next two pages*

	YES	NO
8. Have you had any complications from past dental treatment (i.e.Bleeding or Anesthetics)? Please describe_____	☐	☐
9. Have you had hepatitis or jaundice?	☐	☐
10. Have you had any infectious diseases? Please list_____	☐	☐
11. Have you had recent exposure to communicable infectious diseases, such as measles, chicken pox or tuberculosis?	☐	☐
12. Have you had abnormal bleeding or blood disorders?	☐	☐
13. Have you taken cortisone or steroids?	☐	☐
14. Any history of Bisphosphonate use? (i.e. Alendronate, Risedronate/Actonel, Boniva, Fosamax)	☐	☐
15. FOR WOMEN ONLY: Are you pregnant?	☐	☐

I hereby certify that the above information is correct to the best of my knowledge.

I, the undersigned, consent to the performing of dental treatment agreed to be necessary or advisable by the dentist. I understand that I am free to withdrawal consent at any point during treatment.

I understand that my insurance is a contract between myself and my employer and that I am responsible for payment of treatment that my insurance may not cover. If issues arise it is my responsibility to contact my employer.

_____ _____

Patient (or Parent/Guardian) Signature Date

Continued on next page*

GREAT SLAVE DENTAL CLINIC

DENTAL INSURANCE QUESTIONNAIRE

We will gladly bill your insurance provider for your treatment; however, each and every single insurance plan has its own unique set of frequencies and limits. Due to current privacy laws, many insurance companies **will not** provide us with any information regarding **your plan**. To serve you best, if you could prior to your appointment, take the time to contact your insurance provider and inquire about the following. Then bring this form along at your appointment time, we will enter the information in our computer system to help keep track of your individual limits.

Insurance Provider:_____

Group Number: _____ ID#:_____

Percentages of Coverage:

Basic Treatment: _____%

Major Treatment: _____%

Combined Maximum $_____ Plan Renewal Date: _____

Orthodontic Treatment: _____% Lifetime Limit: $_____

Basic Treatment:

Frequency Of New Patient Exams: Once every_____years (01103 ADULT, 01101 Child)

Frequencies of Recall & Specific Exams: Once every_____months (01202, 01204)

Frequencies of Polishing & Fluoride: Once every_____months (11101, 12111)

Age Limit for Fluoride Treatments: Under_____years old OR _☐_ No age limit

Frequencies for Bitewing X-Rays: Once every 12 months (02142)

Frequencies for Panoramic X-Rays: Once every _____ years (02601)

Number of Units for Scaling & Root Planning Per Benefit Year: _____

Please Note:

Your insurance policy is an agreement between you and the insurance company that provides your benefits. Not all services may be covered by your insurance and any fees not covered are the patient's responsibility. Every insurance plan has its own unique limitations, exceptions and fee schedule, therefore it is the patient's responsibility to understand and advise our office to the limits of the insurance coverage. **We cannot guarantee your individual coverage.**

Your insurance company may request a pre-determination of benefits be submitted prior to treatment. Our office will be happy to submit a pre-determination for any major treatment you may require.

It is your responsibility to update your insurance information with us whenever your insurance plan coverage may change or if you switch to another insurance provider.

Once this form is complete, please email to our office at reception@gsdental.ca