# Copperstone Dental New Patient Form

Patient:Mr./Mrs./Miss_____
                 Surname                         First                    Middle

Date of Birth: _____      Emergency Contact Name: _____
          Day     Month     Year

                                   Phone#: _____

Address: _____ Marital Status: ☐Married ☐Single ☐Common Law
City/Prov: _____ Postal Code: _____ **Email:** _____
Home #: _____ Work #: _____ Cell #: _____
How did you hear about us? Internet Search,  Walk By,  Newsletter,   Website,  Friend/Family Referral(name) _____
Other (please specify) _____

## DENTAL INSURANCE INFORMATION

Insurance Company #1: _____   Insurance Company #2: _____
Policy/Group #1: _____   Policy/Group #2: _____
ID #: _____   ID #: _____
Policy Holder's Name: _____   Policy Holder's name: _____
Policy Holder's Birth Date: _____   Policy Holder's Birth Date: _____
Policy Holder's Employer: _____   Policy Holder's Employer: _____
Patient's Relationship to Subscriber : ☐Self ☐Spouse ☐Child ☐Other_____

## MEDICAL HISTORY

1. Are you currently in good health? ☐Yes ☐No
If no, please explain
_____
2. Are you currently taking any medications or vitamins (prescription, over-the-counter, recreational)? ☐ Yes ☐ No
If yes, please
list_____
3. Do you currently smoke? ☐Yes ☐ No
4. Are you allergic to or ever had a reaction to any of the following: **(please circle)**

Penicillin       Local Anesthetic (Freezing)       Sulfa Drugs       Erythromycin
Codeine       Aspirin (ASA)       Latex       Other _____
5. Are you currently (or within the past 2 years) being treated for any medical condition ☐Yes ☐ No
If Yes, Please explain: _____
6. Do you bleed more or longer than normal after a cut, bruise, surgery or previous tooth removal? ☐Yes ☐No
7. Have you ever had a serious illness or operation? ☐ Yes ☐ No
8. Do you currently have or ever had any of the following conditions? **(please circle)**

| | | | |
|---|---|---|---|
| Heart Trouble or stroke | Heart Murmur | Thyroid Disorder | Rheumatic Fever |
| Breathing Problem | Blood Disorders | HIV + / AIDS | Tumors or Cancer |
| High / Low Blood pressure | Hepatitis ☐A ☐B ☐C | Artificial Joints | Liver /Kidney Disease |
| Depression | Diabetes (Type I/II) | Tuberculosis | Epilepsy or Seizure |
| Anxiety | Asthma | Hormonal Disorder | Covid-19 |

Other: _____
9 Women: Are you Pregnant?      ☐ Yes ☐ No      If yes, which trimester? _____
10. Is there anything else we should know about your health? ☐ Yes ☐ No If so, please explain: _____

## DENTAL HISTORY

1. What dental condition(s) concern you at present? _____
2. When was your last dental check-up and cleaning? _____
3. Were X-rays taken at your last dental visit?      ☐ Yes ☐No
**4.** Have you noticed any signs of the following? **(please circle)**

Bleeding gums      Swelling of Gums      Gum Ache      Receding Gum      Loose Teeth      Drifting of Teeth
5. Do you have any clicking, popping or pain in your jaw joint?      ☐ Yes ☐ No
6. Are you aware of clenching or grinding your teeth?      ☐ Yes ☐ No
7. Do you have any missing teeth that you feel should be replaced?      ☐ Yes ☐ No
8. Would you like to improve the appearance of your teeth?      ☐ Yes ☐ No
9. Do you floss your teeth?      ☐ Yes ☐ No
10. Have you had any complications or difficulty with previous dental treatment?
11. How do you rate yourself as a dental patient?      ☐ Calm      ☐ Lightly Nervous      ☐ Very Anxious

I hereby certify that the Medical and Dental Histories provided are accurate and complete to the best of my knowledge. I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic or any drugs as indicated and I will assume responsibility for fees associated with those procedures.

Date_____         Signature_____

# COPPERSTONE DENTAL OFFICE POLICIES

### APPOINTMENT REMINDERS
Please understand that it is **your responsibility** to keep track of your appointments. We will do everything we can to remind you of them in adequate time for you to make arrangements or changes for that appointment.

### CANCELLATIONS
Due to a continuous high demand in prime appointment times, we require a **minimum of 48 hours** notice to cancel or reschedule an appointment. This is time that the Doctor and staff have reserved specifically for you. If the office does not receive 48 hours notice to cancel or reschedule an appointment, a **fee of $150** may be applied.

### DIRECT BILLING INSURANCE & PAYMENT ARRANGEMENTS
Due to the Canadian Personal Privacy Act, we are unable to access any sufficient information from your insurance company regarding your dental plan. It is **your responsibility** to know the details involved in your plan such as annual maximums, frequencies, and any other limitations. We extend the **courtesy to bill your insurance** directly, however to avoid any patient portion discrepancies, please be fully aware of the particulars of your plan so you can utilize your benefits to their maximum. **Copperstone Dental** can also provide estimates when requested so you may budget your finances accordingly.

**Copperstone Dental** is pleased to offer you the following payment options. Please **CHECK** which option you would like to participate in.

☐ **Option A:** **INSURANCE WILL BE PAYABLE TO THE PATIENT**
Payment is due **in full** the day of treatment is completed. We accept Cash, Visa, Debit and MasterCard. Your payment will be processed & insurance documents will be generated for you to submit to your insurance carrier. An insurance cheque will be sent directly to you from your insurance carrier.

☐ **Option B:** **WE DIRECT BILL TO INSURANCE – PAYMENT IS PAYABLE TO THE DENTIST**
You will be required to leave your credit card number on file and we will direct bill your insurance company. Any outstanding amounts will be applied to your credit card on file once your insurance company has paid us their portion. If we receive an explanation of covered costs from your insurance company at the time of your visit, you will be required to pay the outstanding balance before you leave.

# I have read & understand the above policies.

_____          _____
Patient/Guardian Signature                                    Date

For **Option B only:**

I hereby authorize any outstanding balances not covered by my insurance carrier to be automatically applied to:
Card #: _____/_____/_____/_____ Expiry Date :_____(mm/yr)
CVV _____      **VISA      MASTERCARD**

Name **(on credit card)**_____ Applies to:_____

Signature of Cardholder:_____

**Receipts will be emailed to the following email address: _____ (if requested)**