wavedental uxbridge

New Patient Information

Whom may we thank for referring you? _____

ABOUT YOU

Name _____ I prefer to be called _____

Birth Date ____/____/_____ Age _____ ☐ Male ☐ Female ☐ _____

☐ Minor Child ☐ Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widowed

Name of Parent(s)/Guardian (Minor Child Only) _____

Primary Caregiver is (Minor Child Only) ☐ Same as above ☐ _____

Home Address: _____

City _____ Prov _____ Postal Code _____

Home Phone*** _____ Work Phone*** _____ Ext _____

Cell Phone*** _____ Email _____

Preferred Contact method: ☐ Home ☐ Cell ☐ Work ☐ TEXT* ☐ EMAIL*

*A valid phone number is required regardless of your contact preference. By providing your cell number/email address you are agreeing to receive communications via SMS, email and voice from our office regarding your appointments and care. You may opt out at any time via text or email, or just let us know.

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above

Name _____ Birth Date: ____/____/_____ Relationship _____

Biling Address _____

City _____ Prov _____ Postal Code _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Email _____

Preferred Contact method: ☐ Home ☐ Cell ☐ Work ☐ TEXT* ☐ EMAIL* (*you may opt out of text or emails at any time)

DENTAL INSURANCE INFORMATION

☐ No Insurance (please continue on back) ☐ On File ☐ NIHB ☐ ODSP ☐ Healthy Smiles

☐ Ontario Works (OW) – **Please note, we DO NOT accept the OW program. All fees billed are payable at current GP Fee Guide and are due at the time of service.**

Primary Insurance

Card Holder Name _____ Birth Date ____/____/____

Relationship _____ Contact Number _____

Insurance Company Name _____ Group/Policy _____

Certificate # _____ Employer _____

Secondary Insurance

Card Holder Name _____ Birth Date ____/____/____

Relationship _____ Contact Number _____

Insurance Company Name _____ Group/Policy _____

Certificate # _____ Employer _____

ABOUT YOUR HEALTH

Family Doctor Name _____ Last Physical _____

Are you under a doctor's care for anything other than general visits? ☐ No ☐ Yes Reason _____

Specialist Name _____ Reason _____

Hospitalized/Surgery in the last 5 years? ☐ No ☐ Yes Reason _____

Do you use an assistive medical device? (Check all that apply)

☐ Hearing Aids/Device ☐ Wheel Chair ☐ Cane ☐ Walker ☐ Insulin Pump ☐ Pacemaker/ ICD ☐ ☐

Medications

Please include ALL prescriptions, over the counter medications taken daily, herbal/vitamin supplements and daily Aspirin.

*if you need more room, please attach a separate sheet of paper, or provide a pharmacy med list.

Medication	Dosage/Frequency	Reason

☐ No Known Allergies Allergies to: ☐ Latex ☐ Metals ☐ Medications ☐ Food ☐ Environmental ☐ Other

Describe your allergies _____

MEDICAL HISTORY

Please check all that apply.

1 ☐ Extreme Dental Anxiety
2 ☐ Women: Pregnant
3 ☐ Women: Oral Contraceptives
4 ☐ Head, Neck or Mouth Injuries
5 ☐ Heart Disease or Trouble
6 ☐ Heart Murmur
7 ☐ Pacemaker
8 ☐ High Blood Pressure
9 ☐ Low Blood Pressure
10 ☐ Cancer Date:
11 ☐ Radiation Date:
12 ☐ Chemotherapy Date:
13 ☐ Arthritis/Rheumatism
14 ☐ Artificial Joints/Prosthesis Date:
15 ☐ Rheumatic Fever
16 ☐ Blood Disorders (anemia, leukemia, clotting etc)
17 ☐ Excessive Bleeding
18 ☐ Stomach Issues
19 ☐ Kidney Issues
20 ☐ Liver Issues
21 ☐ Diabetes ☐ Type I ☐ Type II ☐ Controlled
22 ☐ Asthma ☐ Controlled
23 ☐ Epilepsy/seizures ☐ Controlled
24 ☐ Tuberculosis
25 ☐ HIV+/AIDS
26 ☐ Hepatitis
27 ☐ Tobacco/Vape/Cannabis Use
28 ☐ Alcohol/Chemical Dependency
29 ☐ Mental Health/Anxiety/Depression
30 ☐ Any other issue not listed: _____

I certify that the above information is complete and accurate. I agree to advise Wave Dental of changes to my health or medication in order to ensure comprehensive care.

X _____ Date _____

Signature of patient, parent or guardian

X _____ Date _____

Signature of Dentist

☐ Digital Signature in Cleardent

APPOINTMENT POLICY

We require a minimum of 24 hours' notice to reschedule or cancel an appointment. Failure to provide this notice will result in the following charges: $25 for the first offence, $50 for the second offence and should it happen again, a $100 charge will be applied, you and your family will be seen on an emergency basis only, or dismissed from our practice.

I have read, understood and will comply with the Appointment Policy listed above: Initials

INSURANCE POLICY

We will prepare and send insurance claims on your behalf, coordinate benefits and accept assignment of benefits. We are not, however, responsible for knowing your insurance coverage, or for any charges in excess of your insurance coverage. **It is ultimately YOUR responsibility to know what your insurance covers including maximums. The person noted above is responsible for all costs incurred in our office above what your insurance covers. Please be advised that the only government programs we accept are ODSP and Healthy Smiles (HSO). We do not accept or direct bill Ontario Works.**

I have read, understood and will comply with the Insurance Policy listed above: Initials

FINANCIAL POLICY

For those without insurance, payment for treatment is due, in full, at the time of service. For those with insurance who are not covered at 100%, the estimated co-pay amount is due at the time of service. We accept cash, debit, visa, mastercard. Financed services can also be paid via etransfer.

If you are covered by a government program such as Healthy Smiles or ODSP, most fees are covered by your government program. If any fees are charged in excess of your program, you will be informed prior to the commencement of treatment. Please note, WE DO NOT ACCEPT ONTARIO WORKS (OW). Any treatment you choose to proceed with will be billed at the current GP fee guide and is payable, in full, at the time of service. We do not direct bill OW, nor will we accept assignment of benefits from OW.

Any major work or procedures requiring a laboratory or ancillary fee will require a deposit in order to book the appointment.

Financing options are available, but require a financial consultation prior to treatment and are subject to credit approval. For all accounts more than 90 days past due, interest will be charged at a rate of 3%/quarter. Accounts not cleared prior to 120 days will have an administrative fee applied and will be sent to collections.

I have read, understood and will comply with the Financial Policy listed above: Initials

AUTHORIZATION AND CONSENT

General Consent to Treatment: I agree and consent to a dental examination by an owner or associate of Wave Dental. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to their commencement. I acknowledge that there are no guarantees, express or implied, as to the results of any procedures or dental treatments performed.

Release of Information: I authorize Wave Dental to release any information regarding my dental/medical history, diagnosis or treatment to health professionals or agents or the law, as required. My personal information will be used for the purpose of contacting me regarding my account, my care or treatment. It will not be sold or released without my express, written consent.

Assignment of Insurance Benefits: I authorize and request my insurance company to pay my benefits directly to Dr. Connie Yong or Dr. Henry Wong, owners of Wave Dental.

I authorize the **Release of Information.** I authorize the **Assignment of Insurance Benefits.**

X _____ Date _____

Signature of patient, parent or guardian