wavedental

New Patient Forms

Whom may we thank for referring you? _____

ABOUT YOU

Name _____ I prefer to be called _____

Birth Date D____/M____/Y_____ Age _____ ☐ Male ☐ Female ☐ Other: _____

Preferred pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

☐ 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 ***(this is how we will confirm appointments)*****: ☐ Home ☐ Cell ☐ Work ☐ TEXT ☐ EMAIL**

Emergency Contact: Name_____ Phone Number:_____Relationship: _____

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above

Name _____ Birth Date: D____/M____/Y_____ 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 ☐ On File ☐ NIHB ☐ ODSP ☐ Healthy Smiles ☐ CDCP

Primary Insurance

Card Holder Name _____ Birth Date D____/M____/Y_____

Relationship _____ Contact Number _____

Insurance Company Name _____ Group/Policy _____

Certificate # _____ Employer _____

Secondary Insurance

Card Holder Name _____ Birth Date D____/M____/Y_____

Relationship _____ Contact Number _____

Insurance Company Name _____ Group/Policy _____

Certificate # _____ Employer _____

Please continue on the back.

ABOUT YOUR HEALTH

The following Information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor- patient confidentiality

Name of Family Doctor: _____Telephone Number: _____

Date of last medical check up: _____

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

Specialist Name _____ Telephone Number: _____

Reason _____

Have you been Hospitalized/Surgery in the last 5 years? ☐No ☐Yes If yes, why: _____

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

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

ALLERGIES: ☐ No Known Allergies Allergic to: ☐ Latex ☐ Metals ☐ Medications ☐ Food ☐ Environmental

☐ Other _____ Describe your allergies _____

Have you ever had ever had an adverse reaction to any local anaesthetic? ☐No ☐Yes If yes, please specify:

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

MEDICAL HISTORY

- ❑ Heart Disease or Trouble
- ❑ Heart Murmur/Mitral Valve prolapsed
- ❑ Head, Neck or Mouth Issues
- ❑ Heart Attack or Stroke Date:
- ❑ Pacemaker
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Thyroid Disease
- ❑ Diabetes Type I Type II (Please circle)
- ❑ Arthritis /Rheumatism
- ❑ Artificial Joints/Prosthesis Date:
- ❑ Scarlet or Rheumatic Fever
- ❑ Cancer; **Date**:
- ❑ Radiation; **Date**:
- ❑ Chemotherapy;**Date**
- ❑ Blood Disorder(anemia,leukemia,clotting)
- ❑ Excessive Bleeding
- ❑ Stomach Issues
- ❑ Kidney Issues
- ❑ Liver Issues
- ❑ Asthma Controlled Y/N
- ❑ Epilepsy
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Hepatitis A/B/C (Please Circle)
- ❑ Mental Health/Anxiety/Depression (Please circle)
- ❑ Tobacco/Vape/Cannibis Use (Please circle)
- ❑ Alcohol/Chemical Dependency (Please Circle)
- ❑ Any other issues not listed_____
- ❑ **FEMALE**: Are you taking any birth control
- ❑ **FEMALE :** Are you Pregnant or Nursing (Please circle)

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

_____ Date _____

Signature of Dentist

DENTAL HISTORY

PLEASE CHECK ALL THAT APPLY

I routinely see my dentist every: ☐ 3 months ☐ 6 Months ☐ 9 Months ☐ Not routinely

1 ☐ Your last Dental Visit was over ONE year ago? If so when _____

2 ☐ Have you ever had trouble getting numb or had any reactions to local anesthetic?

3 ☐ Have you had any cavities within the past 3 years?

4 ☐ Is there anything about the appearance of your teeth that you would like to change?

5 ☐ Are any teeth sensitive of painful to hot, cold, biting, or sweets?

6 ☐ Did you ever have braces or Orthodontic treatment?

7 ☐ Are your teeth crowding; developing spaces; become shorter; thinner or worn in the last 3 years?

8. ☐ Do you bite your nails, lips or cheeks, use your teeth to hold objects, or have any other oral habits?

9 ☐ Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping)

10 ☐ Do you clench or grind your teeth during the day or at night?

11 ☐ Do you wake up with headaches?

13 ☐ Do you wear a Night Guard appliance?

14 ☐ Do you have a dry mouth when you wake up in the morning or throughout the day?

15 ☐ Do you snore or make sounds while asleep?

16 ☐ Do you tend to breathe through your mouth while awake or sleeping?

17 ☐ Do you use a C-PAP Machine?

THE FOLLOWING QUESTIONS PERTAIN TO CHILDREN ONLY

18 ☐ Children: Do you have a history of Thumb/Finger sucking, pacifier or bottle use?

19 ☐ Children: Frequent throat infections?

20 ☐ Children: Have had a Tongue Tie or Frenum Pull released?

21 ☐ Children: Have you had adenoids and tonsils removed or tube in your ears?

APPOINTMENT POLICY

We require a minimum of 24 hours business notice to reschedule or cancel an appointment. Failure to provide this notice will result in the following charges: $25 no show charge will be applied for missed appointments. For patients who miss "No Show" appointments or has canceled their appointments with less than 24 hours notice, three (3) or more times, may be dismissed from the practices.
Patients who appear to be under the influence of drugs or alcohol may be denied treatment, and have their appointments rescheduled.
I have read, understood and will comply with the Appointment Policy 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. We accept, all private insurance as well as ODSP, and Healthy Smiles. It is ultimately your responsibility to know what your insurance covers including maximums. The person signing the forms is responsible for all costs incurred in our office above what your insurance covers.
We also accept the Canadian Dental Care Plan (CDCP). The CDCP fees are lower than the Ontario Dental fee guide so any and all co-pays are the responsibility of the patient/guardian. CDCP plan holders: I understand that the CDCP can audit up to 2 years beyond the date of treatment and payment can be retracted, within that time frame.
I have read, understood and will comply with the Insurance Policy listed above: Initials

FINANCIAL POLICY

Patient/Parent/Guardian assumes full responsibility for payment of fees associated with treatment and services rendered. For those without insurance, payment for treatment is due, in full, at the time of service, unless prior financial arrangements have been made in advance. For those with insurance any fees/co-pays not covered by your insurance company are due in full, at the time of service.
We accept cash, debit, Visa, Mastercard. ***We do not accept personal cheques.***
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, and signed treatment plan prior to treatment. 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

Our privacy protocols comply with Privacy Legislation, Standards of our Regulatory Body, The Royal College of Dental Surgeons of Ontario and the law.
Wave Dental is committed to maintaining a professional, inclusive, and respectful work environment, where all individuals (staff and patients) are treated with dignity, free from harassment, discrimination, and bullying.
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 history, diagnosis or treatment to health professionals, dental specialist, or agents or the law, as required. My personal information will be used for the purpose of contacting me regarding my account, to collect unpaid accounts, 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, owner of Wave Dental Uxbridge.

I understand and will comply with the office **Appointment Policy.**
I understand and will comply with the **Financial Policy.**
I understand and agree to the **General Consent to Treatment.**
I authorize the **Release of Information.**
I authorize the **Assignment of Insurance Benefits.**

X _____ Date _____
Signature of patient, parent or guardian