Date: _____

Welcome To Broadway Dental

Please fill out all 3 pages

Thank You for selecting our dental team. To help us meet all your dental healthcare needs, please fill out the information below. Should you have any questions or need any assistance, please ask and we would be happy to assist you.

Patient Information (Confidential)

First Name:_____ **Preferred Name**: _____

Last Name:_____ **Date of Birth**: M_____D_____Y_____

Phone: **H:** _____ **W:** _____ **C:** _____

Email: _____

Address: _____

City:_____ **Province:**_____ **Postal Code**: _____

Preferred Method of Contact (Please circle): Telephone: H W C Email Text

How did you hear about our office? _____

If Student, Name of School: _____

Employer/ Occupation: _____

Emergency Contact: **Name:** _____ **Phone:** _____

Relation: _____

Insurance Information:

Name of Policy Holder: _____ Date of Birth: _____

Insurance Company: _____

Policy # _____ Id # _____

Basic _____% Major _____%

Limit: _____ Limit: _____ Deductible:_____ Recall: _____

Any Secondary Insurance Coverage_____

Broadway Dental

Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment.

Regarding Payment

Payment for services is due at the time services are rendered. We are happy to extend the courtesy of billing your insurance company directly for your services. If you are covered by insurance, we expect payment for deductibles and co-payment **on the date of service.**

We accept the following forms of payment: *Cash, Debit, Visa and MasterCard.*

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Special Financing

For comprehensive treatment, we also offer a fixed monthly payment plan that allows you to start your treatment today and spread payments over time.

Billing

For all accounts over 45 days with patient amounts owing, there will be a 2% finance charge per month. We assign all accounts over 120 days to a collection service for processing.

Should this account become past due, you agree to pay any reasonable additional fees, including any and all collection agency fees, legal fees and/or court costs, necessary to collect amount owing.

There will be a minimum charge of $75.00 for cancelling an appointment with less than 48 hours' notice.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Guardian:_____ Date:_____

Signature of Administrator: _____ Date: _____

HEALTH QUESTIONNAIRE

To help ensure your well being while receiving treatment in our office, please answer the following questions.
All information will be considered confidential and for our records only. I certify the above information is correct to the best of knowledge.

Last name:_____ **First name:**_____ **Middle initial:**_____ **DOB:**_____

1. **Have you been examined and /or treated by a physician within the last year? YES NO ~ if yes, When?** _____
   Physician's Name:_____ **Physician's Phone:**_____
2. **Have you ever been seriously ill or hospitalized? YES NO *If yes When?** _____
3. **Do you require any antibiotic coverage before any dental treatment? YES NO**
4. **Are you on blood thinners? YES NO *if YES the medication you are taking*:**_____

Please check (√) if you have ever had any of the following: * **Reviewed by:** **Date:**

⊡ Angina - Chest pain	⊡ Infectious/communicable disease	**SENSITIVITIES/ALLERGIES:**
⊡ Arthritis	⊡ Inflammatory rheumatism	⊡ Aspirin
⊡ Artificial Joints (hip/knee)	⊡ Lung/breathing problems	⊡ Codeine
⊡ Asthma	⊡ Mitral Valve Prolapse	⊡ Penicillin (Antibiotics)
⊡ Blood pressure problems : High or Low	⊡ Nervous/mental problems	⊡ Sulfa
⊡ Bruise easily	⊡ Transplants i.e.: Hip/Knee	⊡ Tylenol
⊡ Cancer	⊡ Pacemaker/artificial valves	⊡ Nitrous Oxide (anaesthetic gas)
⊡ Radiation/ chemo treatment	⊡ Prolong bleeding after injury	⊡ Latex
⊡ High risk group for AIDS/HIV	⊡ Persistent cough	
⊡ Cold sores	⊡ Painful swollen joints	Woman only:
⊡ Congenital heart condition	⊡ Rheumatic fever	Are you pregnant? Yes No
⊡ Cortisone/steroid therapy	⊡ Recent change in appetite	If so, how many _____ months
⊡ Diabetes : Type 1 or Type 2	⊡ Severe headaches	
⊡ Difficulty swallowing	⊡ Sinus trouble/ Sore throats	Do you smoke? YES NO
⊡ Earaches	⊡ Stomach/intestinal problems	*** **Are you taking any medications?**
⊡ Feel thirsty much of the time	⊡ Tendency to faint	If so please list:
⊡ Frequent indigestion/vomiting	⊡ Trouble hearing	⊡
⊡ Heart Attack or Stroke ~ When?	⊡ Tumors or growths	⊡
⊡ Heart murmur/ palpitations	⊡ Venereal Disease	⊡
⊡ Liver disease/ Hepatitis Type:	⊡ Bad reaction to anesthetic	⊡

Is there anything else concerning your health not listed that you think the doctor should know about? YES NO

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1) A) When was your last dental visit? _____ B) Name of previous Dentist: _____
2) Have you had regular dental exams in the past? If yes what was done: _____
3) Have you had x-rays taken within the last year? _____
4) Are you having dental discomfort or dental pain? _____
5) Have you ever experienced abnormal bleeding associated with previous extraction, surgery or trauma? YES NO
6) I brush _____ times a day. I floss _____ times a day.
7) Do your gums bleed when brush or floss? NEVER SOMETIMES OFTEN
8) A) Do you have any oral habits: clenching, grinding, nail biting, thumb sucking? YES NO B) Do you wear a night guard? YES NO
9) Have you ever had professional tooth brushing & flossing instructions? YES NO
10) I am interested in sedation. YES NO
11) Have you had any problems with or unpleasant reactions to dental treatment? YES NO
12) A) Are you happy with the appearance of your teeth? YES NO B) Would you like a whiter smile? YES NO
13) A) Have you had Orthodontic treatment in the past? YES NO B) Would you like straighter teeth? YES NO
14) My primary concerns is: _____

Date:_____ **Signature (Patient/Parent/Guardian) :**_____