DR. JOHN L. CHIASSON DENTISTRY (Insurance)

REGISTRATION

Please complete this form to the best of your ability. 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 First:_____Last:_____Initial:____ Date of Birth: (dd/mm/yr):___/____/___

Address: Street_____ City/ Prov:_____Postal Code:_____

Cell:_____ Home / Work:_____Email: _____

Preferred Method of Contact: ___Phone ___ Text ___ Email Preferred Appointments time: am / pm / evening

Are you available for short notice appointments? ___ Yes ___ No How did you hear about us?_____

Emergency Contact: Name:_____Relationship to Patient:_____ Phone

MEDICAL HISTORY

Doctor: Name:_____Phone:_____ **Pharmacy /Location:**:_____

1. Are you being treated for any medical condition at present or have within the past two years? ☐ Yes ☐ No
   If so, why?_____
2. Have you been hospitalized within the past 2 years? ☐ Yes ☐ No
   If yes, please explain_____
3. Do you take any Medications or Non Prescribed Drugs? ☐ Yes ☐ No
   If yes, please list _____
4. Have you ever been advised by your doctor to take antibiotics before dental treatment? ☐ Yes ☐ No
5. Are you immune compromised? If yes, explain_____ ☐ Yes ☐ No
6. Do you have high or low blood pressure? If yes? which _____ ☐ Yes ☐ No
   Do you take blood thinner medication? (If yes, ensure that it is included in your list of medications.) ☐ Yes ☐ No
7. Do you have a blood clotting condition? If yes, explain_____ ☐ Yes ☐ No
8. Have you ever been advised by your doctor to change the doseage or stop taking a medication prior to dental treatment? If yes, please explain_____ ☐ Yes ☐ No
9. Do you use controlled substance , cannibis or tabacco? ☐ Yes ☐ No

ALLERGIES...(check where applicable) __Aspirin __ Latex __ Codeine __ Anaesthetic __Other (specify) _____

_____

Do have or had a history of any of the following? (Please check all that apply)

☐ AIDS or HIV Positive	☐ Chemotherapy	☐ Hepatitis	☐ Paget's Disease
☐ Anaphylaxis	☐ Chronic Cough	☐ Heart Surgery	☐ Psychiatric
☐ Anemia	☐ Cold Sores / Blisters	☐ Heart Murmer	☐ Treatment Rashes / Hives
☐ Angina / Chest Pain	☐ Cortisone Medication	☐ Heart Attack	☐ Radiation
☐ Arteriosclerosis	☐ Diabetes	☐ Pacemaker	☐ Rhumatic Fever
☐ Artifical joints (hip or knee)	☐ Drug / Alcohol Addiction	☐ Heart Disease	☐ Sinus Trouble
☐ Arthritus	☐ Excessive Bleeding	☐ Hemophilia	☐ Stomach / Intestinal Disease
☐ Asthma	☐ Epilepsy / Seizure Disorder	☐ Hypoglycemia	☐ Stroke
☐ Blood Transfusion	☐ Fainting / Dizzy Spills	☐ Liver Disease	☐ Swelling of Limbs
☐ Shortness of Breath	☐ Frequent Headaches	☐ Kidney Disease	☐ Thyroid Disease
☐ Bruises Easily	☐ Genital Herpes	☐ Malignant Hyperthermia	☐ Tuberculosis (TB)
☐ Cancer	☐ Hearing Impaired	☐ Prosthetic Heart Valve	☐ Tumors / Growths / Ulcers

Have you ever had any serious illness or disease not listed above? If yes, explain_____

_____

For Women Only: Are you currently breast feeding or pregnant? ☐Yes ☐ No If pregnant, what is your due date? _____

CONSENT FOR TREATMENT: I the undersigned, certify that I have provided an accurate and complete medical and dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment.

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

DENTAL HISTORY

Please circle Yes or No, where applicable.

PATIENT: _____

Are you in pain or currently experiencing any oral discomfort? ☐ Yes ☐ No If yes, explain_____

When was your last?

Dental visit: _____ Hygiene Visit (Cleaning): _____ Dental x-rays: _____ Panoramic x-ray: _____

How many times a year do you? Visit the dentist: _____ Have Professional Cleaning(s): _____

Do you have:

Tooth sensitivity to heat, cold, sweets or pressure? ☐ Yes ☐ No

Pain or swelling of the gums? ☐ Yes ☐ No

Bad breath? ☐ Yes ☐ No

Growth or sores in your mouth? ☐ Yes ☐ No

Have you ever had any of the following:

Periodontal treatment (treatment of gums)? ☐ Yes ☐ No

Oral surgery (extractions, broken jaw)? ☐ Yes ☐ No

Orthodontic Treatment (braces, retainers, appliance to teeth)? ☐ Yes ☐ No

Dental work done while asleep or sedated while in a dental office or hospital? ☐ Yes ☐ No

Dental work done using freezing and or nitrous gas? ☐ Yes ☐ No

How often do you brush you teeth in a day? _____

What time(s) of the day? AM PM

Do you use an electric toothbrush? ☐ Yes ☐ No

Does you use floss / proxabrush / stimulants to clean your teeth? ☐ Yes ☐ No, If yes how often?_____

Do / Does you(r):

Suffer from heaches? ☐ Yes ☐ No

Clench or grind your teeth? ☐ Yes ☐ No

Experience popping / clicking of jaw joints? ☐ Yes ☐ No

Have pain in your jaw joints and / or near your ear and side of face? ☐ Yes ☐ No

Have pain when opening and closing your jaw? ☐ Yes ☐ No

Your jaw lock when open or closed? ☐ Yes ☐ No

Does having dental treatments make you nervous or uncomfortable? ☐ Yes ☐ No

Have you ever had an upsetting experience in a dental office, or any complications during or following treament? ☐ Yes ☐ No

If yes, explain:_____

Do you feel it is important for you to keep your natural teeth? ☐ Yes ☐ No

Would you like to see any cosmetic changes? ☐ Yes ☐ No If yes, explain:_____

To my knowledge, the questions on this form have been accurately answered. It is my responsibility to inform the dentist of any changes in medical.

Signature Of Patient, Parent Or Guardian _____ **Date**_____

INSURANCE INFORMATION

THE INSURANCE CARD OR PHOTOCOPY OF THE CARD MUST BE BROUGHT TO YOUR APPOINTMENT

PATIENT

NAME: First:_____Last:_____Initial:____ Date of Birth: (dd/mm/yr):____/____/___

Phone Number: Cell:_____ Home:_____ Email: _____

Responsible Party Name: First:_____ Last:_____

Date of Birth: (dd/mm/yr):____/____/___ Phone:_____ Relationship to Patient:_____

Method of Billing: ☐ Non-Assignment ☐ Direct Billing Is there a 2nd Insurance? ☐ Yes ☐ No

POLICY HOLDER'S NAME: First:_____Last:_____

Date of Birth: (dd/mm/yr):____/____/__ Relationship to Patient:_____ Phone:_____

Insurance Company:_____ Group#:_____ ID#:_____

Employer:_____

INSURANCE BREAKDOWN

Please provide us with your Dental Insurance Breakdown, it can be found in your insurance booklet, app, or from your insurance company. This information helps us assist you in ensuring that you do not exceed yearly frequencies, thus avoiding additional expenses. If you have any questions please feel free to ask we will gladly help.

Dental Insurance Breakdown Coverage: Yearly Max: $_____ Term:_____

Basic Coverage (cleanings / fillings ie. 80%): _____% **Major Coverage** (crowns ie. 50%):_____%

Frequency : **Recall** (Regular Exam. ie. 6, 9, 12 mths) / **Polish** / **Flouride**:_____ mths

Scaling Units: (The amount of time that your policy will cover dental cleanings ie. 10 scaling units per year):_____per year

Complete Examination (ie. Visting a New Dentist 1 per 3 years / **Panaromic x-ray**: 1 per_____Years

Notes (Admin):

INSURANCE BILLING, ACKNOWLEDGEMENT, AND AUTHORIZATION

I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR PAYING IN FULL DAY OF TREATMENT, except in the case of Assignment.

I ACKNOWLEDGE that I have familiarized myself with my dental insurance benefits and that **I AM RESPONSIBLE FOR ANY MONIES NOT COVERED BY MY INSURANCE,** either the day of treatment or upon notification from the insurance company

WE WILL DO OUR BEST TO ASSIST YOU IN ANY WAY IN DETERMING YOUR INSURANCE COVERAGE, BUT YOU ARE SOLELY RESPONSIBLE FOR KNOWING AND KEEPING TRACK OF YOUR INSURANCE AND AMOUNT REMAINING.

I hereby, authorize my health care provider to collect, use, and disclose any personal information concerning claims submitted on my behalf with the insurer / plan administrator and their service providers for the purpose of assessing my claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud / plan abuse. I confirm that I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons stated above.

I hereby authorize my health care provider to directly bill my insurance company on my behalf for services provided at Dr. John L. Chiasson Dentistry.

Signature:_____ **Date:**_____

Patient / Responsible Party

TO:

Canadian Dental Association

Canadian Life and Health Insurance Association Inc.

STANDARD DENTAL CLAIM FORM

PART 1 DENTIST

UNIQUE NO. 061316700 | SPEC. | PATIENT OFFICE ACCT NO.
OFFICE NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE NAMED DENTIST AND AUTHORIZE PAYMENT TO HIM/HER.

SIGNATURE OF SUBSCRIBER

PATIENT

DENTIST
Chiasson, Dr John
1470 Mosley Street, Unit 8
Wasaga Beach ON L9Z 2C2

PHONE NO.(705) 352-1028

FOR DENTIST USE ONLY - FOR ADDITIONAL INFORMATION, DIAGNOSIS, PROCEDURES,OR SPECIAL CONSIDERATIONS.

DUPLICATE FORM []

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY DENTIST FOR THE ENTIRE TREATMENT. I ACKNOWLEDGE THAT THE TOTAL FEE OF

$ IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS CLAIM FORM TO MY INSURING COMPANY / PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTIST.

X
SIGNATURE OF PATIENT (PARENT/GUARDIAN)

OFFICE VERIFICATION

DATE OF SERVICE DAY	MO.	YR.	PRO-CEDURE CODE	INTL. TOOTH CODE	TOOTH SURFACES	DENTIST'S FEE	LABORATORY CHARGE	TOTAL CHARGES

FOR CARRIER USE

ALLOWED AMOUNT	INC	%	PATIENT'S SHARE

CHEQUE NO. | DATE

DEDUCTIBLE | PATIENT PAYS | PLAN PAYS

CLAIM NO.

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND THE TOTAL FEE DUE AND PAYABLE, E & OE.

TOTAL FEE SUBMITTED $

INSTRUCTIONS FOR CLAIM SUBMISSION

BEING A STANDARD FORM, THIS FORM CANNOT INCLUDE SPECIFIC INSTRUCTIONS ON WHERE IT SHOULD BE SENT, DEPENDING ON WHO IS THE CARRIER FOR YOUR PLAN. YOU CAN OBTAIN DETAILS FROM EITHER YOUR PLAN BOOKLET, YOUR CERTIFICATE OR FROM YOUR EMPLOYER.
IF YOUR PLAN REQUIRES SUBMISSION DIRECTLY TO THE CARRIER, PLEASE SEND THIS FORM WITH ONLY PARTS 1, 2 AND 3 COMPLETED TO THE CARRIER'S APPROPRIATE CLAIMS OFFICE.
***IF YOUR PLAN REQUIRES SUBMISSION TO YOUR EMPLOYER, PLEASE DIRECT THIS FORM TO YOUR PERSONNEL OFFICE/PLAN ADMINISTRATOR WHO WILL COMPLETE PART 4 AND FORWARD THE FORM TO THE CARRIER.**

PART 2 - EMPLOYEE/PLAN MEMBER/SUBSCRIBER

1. GROUP POLICY/PLAN NO. _____ DIVISION/SECTION NO. _____ 2. YOUR NAME (PLEASE PRINT) _____

EMPLOYER _____ YOUR CERT. NO. OR I.D. NO. _____ For Dep. #

NAME OF INSURING AGENCY OR PLAN _____ YOUR DATE OF BIRTH _____
DAY MONTH YEAR

PART 3 - PATIENT INFORMATION

1. PATIENT: RELATIONSHIP TO EMPLOYEE/ PLAN MEMBER/SUBSCRIBER _____

DATE OF BIRTH _____ IF CHILD INDICATE: ☐ STUDENT ☐ HANDICAPPED

IF STUDENT, INDICATE SCHOOL _____

PATIENT I.D. NO. _____

2. ARE ANY DENTAL BENEFITS OR SERVICES PROVIDED UNDER ANY OTHER GROUP INSURANCE OR DENTAL PLAN, W.C.B. OR GOV'T PLAN? ☐ NO ☐ YES

POLICY NO. _____ SPOUSE DATE OF BIRTH _____

NAME OF OTHER INSURING AGENCY OR PLAN _____

3. IS ANY TREATMENT REQUIRED AS THE RESULT OF AN ACCIDENT? IF YES, GIVE DATE AND DETAILS SEPARATELY. ☐ NO ☐ YES

4. IF DENTURE, CROWN OR BRIDGE, IS THIS INITIAL PLACEMENT? GIVE DATE OR PRIOR PLACEMENT AND REASON FOR REPLACEMENT. ☐ NO ☐ YES

5. IS ANY TREATMENT REQUIRED FOR ORTHODONTIC PURPOSE? ☐ NO ☐ YES

6. I AUTHORIZE THE RELEASE OF ANY INFORMATION OR RECORDS REQUESTED IN RESPECT OF THIS CLAIM TO THE INSURER / PLAN ADMINISTRATOR AND CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT, AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

DATE _____
DAY MONTH YEAR

X _____
SIGNATURE OF EMPLOYEE/PLAN MEMBER/SUBSCRIBER

PART 4 - POLICY HOLDER/EMPLOYER (FOR COMPLETION ONLY IF APPLICABLE. SEE ABOVE*)

1. DATE COVERAGE COMMENCED
2. DATE DEPENDENT COVERED
3. DATE TERMINATED

DAY	MONTH	YEAR

4. CONTRACT HOLDER

DATE
DAY MONTH YEAR

AUTHORIZED SIGNATURE

(POSITION OR TITLE)

ALL INFORMATION RECORDED ON THIS FORM IS CONFIDENTIAL

FINANCIAL AGREEMENT: NON-ASSIGNMENT / ASSIGNMENT (DIRECT BILLING)

PATIENT:_____ **INSURANCE:** ☐ **NON-ASSIGNMENT** ☐ **ASSIGNMENT**

As a condition of your or your child's treatment by this office, financial arrangements must be made prior to treatment; this includes dental emergencies . **PAYMENT IS DUE IN FULL AT TIME OF APPOINTMENT,** unless an alternative financial agreement has been made. We accept Cash, Visa, Mastercard, and Debit. Personal cheques will not be accepted.
Our office will submit dental insurance claims electronically, when able, or via mail / email immediately following treatment. Your Dental Insurance Policy is a contract between the policy holder and the insurance company. Our office **WILL NOT** enter into a dispute with your insurance company over any claim.

It is the responsibility of the patient / responsible party to be aware your dental benefits / coverage and when changes occur; not our office. We will assist you to the best of our ability when we can, including explaining and answering insurance questions.

Pre-determinations to your insurance company to see if coverage will covered will be submitted upon request; we require at least 3 business days notification prior to dental treatment. Due to the privacy act the results, in most cases, are emailed directly to the insuree via their insurance app. If a patient proceeds with treatment prior to approval, and it is declined, the responsible party is fully responsible for the cost of treatment. The results of predetermination for major treatment, such as crowns and bridges may take to 6 weeks depending on the insurance company.
Treatment recommendations made by Dr. Chiasson or the providers are based on what they think is best for the patient, and not your dental insurance.

NON-ASSIGNMENT:

Payment is due in full day of treatment; the insurance company will send payment directly to the policy holder, and you will not have an outstanding balance owing.

ASSIGNMENT (Direct Billing):

THE PATIENT / RESPONSIBLE PARTY ARE RESPONSIBLE FOR PAYING THEIR CO-PAY, AND ANY MONIES NOT COVERED BY THE INSURANCE COMPANY DAY OF TREATMENT, OR UPON NOTIFICATION. Your insurance company will send payment to our office. (i.e. the insurance company will pay our office 80% of the amount you are eligible for and the patient will pay 20% , and if applicable, any monies not paid for by the insurance company day of treatment.) Your insurance company provides us with us with an Explanation of Benefits (EOB) which outlines the payment breakdown down for services rendered. In some cases an EOB is not provided , in which case we will collect the co-pay, day of treatment, and, if applicable, any outstanding balance remaining will automatically be billed. Payment is expected immediately. **IF PAYMENT HAS NOT BEEN RECEIVED FROM YOUR INSURANCE COMPANY WITHIN 90 DAYS** following treatment, the responsible party is expected to pay the account in full, and they become responsible for obtaining reimbursement directly from their insurance company. By accepting your insurance on assignment, we are extending you CREDIT. This courtesy may be withdrawn at any time,with advance notice.

CANCELLATION POLICY

We try our very best to offer you appointments that accommodate your schedule. This time is reserved just for you, and has been scheduled by you. In order to give you the best care possible and to be fair to all our patients and team, we ask that you make every effort to keep these appointments. If you are unable to keep your appointment, we ask that you provide us at least two business days notice. Short Notice Cancellations and Missed Appointments may result in a $50 service fee. As a courtesy, automated text and email reminders are sent prior to appointments. We ask that you please confirm your appointment by responsding to the text / email, or calling the office. Your dental appointment is confirmed until we receive a verbal cancellation.

CONSENT

In accordance to the Federal and Provincial Privacy Legislation we will not disclose personal information and / or xray(s). However at times we do need to use the information for the following purposes: assess dental treatment,specialist referrals, appointment confirmations, account management, insurance purposes, and comply to regulatory requirements.

I HAVE READ THE ABOVE CONDITIONS PERTAINING TO PAYMENT AND INSURANCE, CANCELLATIONS, AND AGREE TO THEIR CONTENT.

Patient / Responsible Party (Signature):_____ Date:_____

DENTAL RECORDS RELEASE FORM

Patient Name to Transfer: _____

Date of Birth: _____ Phone Number: _____

Other Family Members to Transfer:

1. _____ 2. _____

3. _____ 4. _____

Previous Dentist or Dental Practice Name: _____

City: _____

Phone Nunber: _____ Fax: _____

E-Mail: _____

Please forward the following information that you have: x-rays, probing depth chart, charting and photographs to **Dr. John L. Chiasson**.

Last Complete Exam:

Last Recall / Polish / Flouride: Frequency:

Last Cleaning : Frequency:

Last BW's / Panoramic:

I hereby give you permission to release any and all dental records to **Dr. John L. Chiasson**

_____ _____

Patient's Signature (guardian if minor) Date

Dr. John L. Chiasson Dentistry

1470 Mosley Street, Unit #8

Wasaga Beach, ON L9Z2C2

705.352.1028 / contact@drjohnchiasson.com