MONASHEE DENTAL CENTRE

PERSONAL INFORMATION

NAME: ……..

BIRTHDATE DD: …... MM: ……. YY: ……...

HOME PHONE #: ……..

CELL PHONE #: ……..

WORK PHONE #: ……..

ADDRESS: ……..

CITY: …….. P/CODE: ……...

EMAIL ADDRESS : ……..…

PARENTS NAME (if under 18): ……..

EMERG. CONTACT (Name): ……..

EMERG. CONTACT (Phone No.): ……

EMPLOYER: ……..…

CARE CARD #: ……..

RECOMMENDED BY: ……..

Would you like to be set up for automatic appointment reminders? **YES** **NO**

If yes, **TEXT** or **EMAIL**

Dental History:

Do you have any dental problems at present? …….. **YES** **NO**
If yes, please specify: ……
When was your last dental visit? .....
Do you visit the dentist regularly? **YES** **NO** If yes, how often? ……
Name of previous dentist? ……..
Do you have any habits such as clenching / grinding your teeth, nail biting or thumb/finger sucking? (Circle all that apply)
Are you unhappy with the appearance of your teeth…….. **YES** **NO**
Are you interested in teeth whitening?..... **YES** **NO**
What type of toothbrush (manual/electric), mouthwash and floss do you use? ……

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE, OUR OFFICE WILL BE PLEASED TO PROCESS YOUR DENTAL INSURANCE CLAIMS ON YOUR BEHALF, AND IT IS THE RESPONSIBILITY OF THE INSURED TO PAY ANY CHARGES NOT PAID BY THE INSURANCE COMPANY.

…… ……

Date Patient or Parent/Guardian Signature

Medical History:

PHYSICIAN'S NAME: _____ PHONE #:_____

Have you had a Medical exam in the past year…… **YES** **NO**

Are you being treated for any condition by a physician now? **YES** **NO** If yes; what: ……..

Have you ever reacted adversely to any of the following? (Please circle all that apply)

Aspirin	**Penicillin**	**Iodine**	**Barbiturates**	**Flouride**	**Local Anaesthetic**
Codeine	**Sulfa drugs**	**Latex**	**Ibuprofen**	**Acetaminophen**	

Do you have any other allergies? **YES** **NO** Please list: ……..

Have you ever had or do you have any of the following diseases or conditions?

Please underline and list beside any medications, if applicable, currently prescribed for the following conditions:

AIDS/HIV……..…..
Adult Jaundice……..
Anemia……..……
Arthritis……....
Artificial Heart valve……..
Artificial Joint (knee, hip, other)……...
Asthma……
Blood disorders……..
Cancer……..…..
Cholesterol……..
Diabetes……..
Epilepsy……..…..
Heart disease/attack……..
Heart pacemaker……..……..

Hepatitis A B C……..…
High/Low Blood pressure……..…..
Kidney disease……..
Mental/Nervous disease……..…..
Mitral valve prolapse……..…..
Organ transplant/medical device……...
Radiation /chemotherapy……..…..
Rheumatic fever……
Stroke……...
Sexually transmitted disease……
Stomach/Intestinal problems……
TB/Lung disease……
Thyroid disease (Hyper/Hypo)……..…..

Other medications or conditions not listed above or further details:

……
……

Do you bruise or bleed abnormally? ……..……**YES** **NO**

Have you ever had any injury, surgery or radiation on your face or jaws? ……..……**YES** **NO**

Are you on any special diet? ……..……..…**YES** **NO**

Are there any genetically linked disorders in your family? ……..…**YES** **NO**

Do you currently have, or have had in the past, any disease, condition or problem not listed above?

If yes, please specify: ……..……

Do you smoke or chew tobacco? **YES** **NO** How Long?..... How much per day?.....

Women only:

Are you pregnant or suspect you may be? ..... **YES** **NO**

Are you taking birth control pills? ……..…… **YES** **NO**

…… ……..……

Date Patient or Parent/Guardian Signature

Monashee Dental Centre

Dr. Paula Winsor-Lee & Dr. Remy Winklmeier
(250) 547-2104
2000 Norris Ave, Lumby, BC, V0E 2G0
mdcsmile@telus.net

Welcome to Monashee Dental! Thank you for selecting our office for your dental care. We are committed to providing excellent dental care with concern for your personal needs. The following information will acquaint you with our office financial policies and allow us to provide a high quality of service to you.

- **Insurance Benefits:** We are happy to complete and submit your insurance forms on your behalf. Every effort will be made to collect the maximum benefits allowed by your insurance company. However, your insurance is a contract between you, your employer and your insurance company. We ask that you read your policy carefully. Some or all of the services we provide may not be a covered benefit. We cannot guarantee the payment level that is quoted nor have information on benefits used in any other dental office if used within your plan year. Any balances remaining after your insurance pays, are due within 15 days of billing. Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge and tracking of benefits as well as benefit amounts, annual maximum limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Booking and receiving your services indicates your acceptance of responsibility to pay regardless of our estimate.
- **Payment:** Our policy is to collect FULL PAYMENT at the time of service. If insurance benefits apply, patient PORTION and DEDUCTIBLES are due at the time of service, unless other arrangements have been made ***prior*** to the service date. A service charge of 2.4% per month (28.8% APR) will be applied for balances due past 30 days. All charges not paid by your insurance company are your responsibility regardless of the reason for non-payment. Not all the services we provide are covered benefits.
- **Minor Patients:** The adult accompanying the minor (under the age of 18) is responsible for full payment of the services provided that day. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made; this ensures that we can provide the essential treatment in an informed manner. In case of divorce or separation, the parent authorizing treatment (signing consent) for a child will be the parent responsible for those subsequent charges. It is the authorizing parent's responsibility to collect from the other parent if necessary.
- **Missed Appointments:** For the courtesy of other patients that are waiting for appointment times, please be aware that we require a 24 hour notice to change or cancel an appointment to avoid a $50.00 charge.

PAYMENT OPTIONS

We accept: VISA, MASTERCARD, OR CASH

CONSENT FOR CARE:

I request the consultation services of Dr. Paula Winsor-Lee or Dr. Remy Winkelmeier. I authorize the doctor to take any necessary x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of treatment needs. I understand this may include consultation with my physician or other practice specialists. I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

_____	_____	_____
Date	Print Name	Patient/Guardian Signature