Miralta Dental Care – New Patient Intake Form

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name:

First_____Middle_____ Last_____

Preferred Name_____

Title: Dr._____ Mr. _____ Mrs. _____ Ms. _____

Gender: Male____ Female____

Status: Married_____ Common-law _____ Single_____ Child _____

Birth Date: (DD/MM/YY) _____

E-mail Address: _____

Phone: Home _____ Work _____

Mobile _____

Best time to call: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Whom may we thank for referring you

Name: _____

Facebook_____

Postcard _____

Miralta.ca _____

Other: _____

Please indicate if you have experienced any of the following:

Allergy- Erythromycin □
Allergy- Aspirin □
Allergy- Codeine □
Allergy- Latex □
Allergy- Local Anesth□
Allergy- Penicillin □
Allergy- Sulfa□
Anemia □
Arthritis □
Artificial Joints □
Asthma □
Birth Control Pill □
Blood Disease □
Cancer □
Diabetes □
Dizziness/ Fainting □
Emphysema □
Epilepsy □
Excessive Bleeding □
Excessive Bruising □
Gastro-Intestinal Concerns □
Glaucoma □
Hard to Freeze □
Hay Fever□
Head Injury □
Hearing Disabled □
Heart Disease □
Heart Murmur □
Hepatitis A □
Hepatitis B □
Hepatitis C □
HIV+ (AIDS) □
High Blood Pressure □
Hives □
Jaundice □
Kidney Disease □
Liver Disease □
Low Blood Pressure □
Mental Disorders□
Multiple Sclerosis □
Nervous Disorders □
Pacemaker □
Radiation Treatment □
Respiratory Problems □
Rheumatism □
Rheumatic Fever □
Rheumatoid Arthritis □
Sinus Problems □
Skin Rash □
STD □
Stomach Problems □
Stroke □
Sleep Apnea □
Snoring □
Thyroid Disease □
TMJ □
Tobacco Use □
Tuberculosis □

What (If any) medications and vitamins are you currently taking?

_____

What (If any) Medications are you allergic to?

_____

Do you require Pre-medication for dental treatment?

_____

WOMEN ONLY:

Are you pregnant? Yes _____ No _____ If Yes, when is the due date?_____

III. DENTAL HISTORY:

A. What concerns you most about your dental health?_____

How do you rate your smile?_____

		YES	NO
B.	Do you see a dentist on a routine basis?	❑	❑
	i - Date of last dental visit? _____		
	ii - Date of last dental cleaning?_____		
	iii - Date of last full mouth series of X-rays? _____		
C.	Are you having pain at this time?	❑	❑
D	Have you ever had:		
	i - Orthodontic treatment (Braces)? _____	❑	❑
	ii - Oral Surgery? _____	❑	❑
	iii - Periodontal treatment (Gum Surgery)? _____	❑	❑
	iv - Worn a bite guard or other appliance? _____	❑	❑
E.	Have you noticed any loosening of your teeth?	❑	❑
F.	Does food tend to become caught between your teeth?	❑	❑
G.	Do you suffer from pain and/or swelling of your gums?	❑	❑
H.	Do your gums often bleed when you brush your teeth?	❑	❑
I.	Problems of the jaw. Have you experienced:		
	i - Clicking of the jaw?	❑	❑
	ii - Pain (joint, ear, side of face)?	❑	❑
	iii - Difficulty in opening or closing?	❑	❑
	iv - Difficulty in chewing?	❑	❑
J.	Habits. Do you:		
	i - Clench or grind your teeth while awake or asleep?	❑	❑
	ii - Bite your lips or cheeks regularly?	❑	❑
	iii - Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, fingernails)	❑	❑
	iv - Mouth breathe while awake or asleep?	❑	❑
K.	Do you feel nervous about having dental treatment?	❑	❑
L.	Have you ever had an upsetting experience in a dental office?	❑	❑
M.	Is it important to keep your teeth?	❑	❑
N.	Are you dissatisfied with the appearance of your teeth?	❑	❑
	If you could, what features of your smile would you like to change?_____		
	_____		
O.	Is there anything else about having dental treatment that bothers you?	❑	❑
	Please explain: _____		
	_____		

Insurance:

Primary Insurance:

Main Policy Holder: Myself_____ Spouse_____ Mother _____Father _____

Name of Primary Policy Holder: _____

Birthdate of Primary Policy Holder: _____

Name of Insurance Company: _____

Policy/Plan/Group # _____ Certificate / ID # _____

Secondary Insurance:

Main Policy Holder: Myself_____ Spouse_____ Mother _____Father _____

Name of Secondary Policy Holder: _____

Birthdate of Secondary Policy Holder: _____

Name of Insurance Company: _____

Policy/Plan/Group #_____ Certificate / ID # _____

Agreement and Consent for Services:

Miralta Dental Care depends on reimbursement from patients and/or their benefits for costs incurred in their care. Our office can file dental claims on your behalf, but are not a party to any insurance programs or contracts. Your dental benefits are a contract between yourself, your employer and your insurance provider. Per the Privacy Act, your plan details will not be released to us, as it is confidential medical information.

For dental services that I have consented to, I will assume responsibility for associated fees. I understand that financial responsibility on the part of each patient must be determined before treatment. An interest charge of 18% per annum will be charged on balances exceeding 90 days, unless previous written agreements are satisfied. I assume responsibility for all costs, should I have any delinquent balances forwarded to a third party collections agent.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

I have read the above conditions of treatment and payment and agree to their content

Publicaiton of records: I authorize Miralta Dental Care to take photos, slides, radiographs, videotape, digital images or any other images of my case and treatment prior to, during, and after its completion. I understand that any images may be used for the advancement of dentistry and for the marketing and promotional use of the practice and for third party purposes. I give unrestricted use of all these materials to Miralta Dental Care.

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Miralta Dental Care in the administraiton of your benefits in accordance with HIPAA, PIPA, and the Privacy Act of Canada. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. These parties may be disclosed to an affiliate that performs services for Miralta Dental Care in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communicaitons without user permission, and do not send spam.

I agree to allow Miralta Dental Care and Demandforce to use this information in providing my services

_____

Signature of Patient (or legal guardian) Date