AXIS DENTAL

Patient's name: ______________________________ Dr. ___ Mr. ___Mrs. ___Ms. ___Miss ___

Preferred to be called: ____________________ Date of Birth: ________________________
(day/month/year)

Address: ___________________________________ Home Phone: ____________________

City/Province _______________________________ Cell Phone: ______________________

Postal Code: __________________________ Work Phone (if you wish)____________________

Occupation: __________________________ Company:_____________________________

Email: _____________________________________ May we call you at work? YES NO

How did you find out about our practice? Friend/Relative, Internet, Facebook, Advertising, Other __________

Family Physician: ___________________________________ Phone: ____________________

In case of an emergency, please contact _______________________ Phone: ________________

Person responsible for account (Please circle) Self Spouse Other _____________________________

Do you have Dental Insurance YES NO

OFFICE POLICY

APPOINTMENTS

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, the time is reserved for you. Therefore at least 24 HOURS NOTICE MUST be given if cancellation is absolutely necessary. A NO SHOW Fee for $75 will be charged if no notice of cancellation is given.

PAYEMENT OF FEES

1. Fees are due and payable when services are rendered.
2. Method of payment can be cash, credit, debit or a certified cheque.
3. The office will assist you in getting payment from your dental plan for services which your plan covers.
4. It is not the offices responsibility to find out what your insurance covers. We will do our best to assist you.

GENERAL RELEASE and CONSENT

I, the undersigned, certify that I have provided an accurate and complete personal and medical and dental history and have not knowingly omitted any information. I hereby authorize the doctor to take x-rays, photographs, study models, or any other diagnostic aids deemed appropriate by the doctor to make appropriate diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated and consent to the use of local anaesthetic agents. I understand the above statements regarding the payment of fees and accept the responsibility for payment for Dental Services provided for myself or my dependents, due and payable when services are rendered.

Patient Signature: ________________________________Date:________________

Have you ever been treated for any of the following?

(Please check all that apply)

☐ **Anaemia**	☐ **Excessive Bleeding**	☐ **HIV/ AIDS**
☐ **Artificial Joints**	☐ **Fainting**	☐ **Pacemaker**
☐ **Asthma**	☐ **Glaucoma**	☐ **Radiation Therapy**
☐ **Blood Disease**	☐ **Heart Disease**	☐ **Respiratory Problems**
☐ **Cancer**	☐ **Heart Murmur**	☐ **Rheumatic Fever**
☐ **Diabetes**	☐ **Hepatitis A, B, C**	☐ **Sinus Problems**
☐ **Dizziness**	☐ **High Blood Pressure**	☐ **Stroke**
☐ **Epilepsy**	☐ **Kidney Disease**	☐ **Tuberculosis**
☐ **Emotional or Nervous Disorde**	☐ **Liver Disease**	
Are you pregnant? **If yes, how many months?**		

Are you presently under any medical treatment?	☐ Y ☐ N	If yes, what?
Taking any medications?	☐ Y ☐ N	If yes, what? • • • • •
Do you have any allergies?	☐ Y ☐ N	If yes, what? • • • • •
Do you smoke?	☐ Y ☐ N	
Loss or gained an excessive amount of weight?	☐ Y ☐ N	
Are you on any special diets?	☐ Y ☐ N	
Do you snore?	☐ Y ☐ N	
Do you gasp or stop breathing in your sleep?	☐ Y ☐ N	
Ever had any major operations or illness?	☐ Y ☐ N	If yes, what? • • • • •

Signature/Parent Signature______________________________ Date___________________