URBAN OASIS
DENTAL STUDIO

WELCOME TO OUR PRACTICE

In order to help us provide you with the best dental experience, please complete the following confidential information.

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Preferred Name: _____ Date of Birth: D: _____/M: _____/Y: _____

Gender: Male / Female

Address: _____

City: _____ Province: _____ Postal Code: _____

Home#:_____ Work #:_____ Cell#:_____

Email Address: _____ Occupation: _____

Employer: _____

Emergency Contact: _____ Phone: _____

How did you hear about our practice?

Please check all items that apply, if a friend or family member referred you please share their name so we can thank them for their confidence is recommending our office

__ Internet __ Staff __ Street Sign __ Live in area __ Medical Office/Pharmacy
__ Friend __ Family

INSURANCE INFORMATION

Please provide card for the front end staff so they can photocopy it for our records.
If you do not have the card, please provide:

Insurance Company: _____

Policy number: _____ Certification Number: _____

Maximum yearly benefit _____ Renewal Date _____

POLICY FOR DIRECT BILLING

We are happy to bill your insurance directly as a courtesy to you but please review the following information.

- The percentage that your insurance company covers is on their fee guide not ours, this may result in a patient balance even for 100 % coverage
- Your insurance is an agreement between you and the insurance company. They will not provide the dental office with your dental information
- All pre-authorizations must be presented to the staff when you are booking the appointment so that we can review the information. Most insurance companies do not provide us with a copy. Please note that a preauthorization does not guarantee coverage from the insurance companies.
- It is crucial for you to know your yearly maximum, renewal date, limitations, and to be aware of accumulated amounts used on your dental plan
- As there are many variables dealing with the insurance company we do require a credit card to guarantee your insurance coverage. We will send you an email prior to charging the credit card so you can have the opportunity to come in and pay with a different method if you want. If we have not heard from you in 3 days your card will be charged.
- I agree to pay any legal or collection fees necessary to reconcile my account.

_____

Signature of patient or insurance holder

I give permission to Urban Oasis Dental Studio to charge the listed credit card as per the above agreement.

Name on Card _____

Credit Card #_____

Expire Date: _____

MEDICAL HEALTH HISTORY

Are you in good health? YES NO

Has there been a change in your health within the last year? YES NO

If yes please explain: _____

Have you been hospitalized or had a serious illness in the last 5 years? YES NO

If yes please explain: _____

Name of Medical Doctor: _____

Date of last complete physical: D: _____/_M:_____/_Y:_____

Please Check All Boxes That Apply To Your Current Health

( ) Chest Pain
( ) Diarrhea, constipation, blood in the stool
( ) Swollen ankles
( ) Difficulty urinating, blood in urine
( ) Shortness of breath
( ) Seizures
( ) Recent weight loss/gain
( ) Asthma - Inhaler
( ) Ulcers
( ) Tumors, Cancer
( ) Persistent cough
( ) Dry mouth
( ) Bleeding problems
( ) Jaundice
( ) Sinus problems
( ) Joint pain, stiffness
( ) Difficulty swallowing
( ) Sleep apnea or chronic snoring
( ) Frequent vomiting, nausea
( ) Blurred vision
( ) Dizziness or Fainting
( ) Hepatitis A B C

( ) Ringing in the ears
( ) Frequent headaches
( ) Mental/ Nervous Disorders
( ) Skin disease
( ) Heart Disease or Heart Murmur
( ) HIV or AIDS
( ) Acid Reflux
( ) Eye disease
( ) Stroke
( ) Arthritis
( ) Colitis
( ) Diabetes
( ) Rheumatic fever
( ) Anemia
( ) High Blood/ Low Pressure
( ) VD (syphilis or gonorrhea)
( ) TB, Emphysema
( ) Herpes
( ) Kidney / Bladder disease
( ) Thyroid / Adrenal disease
( ) Alcohol/Drug Abuse
( ) Artificial joint

( ) NONE OF THE ABOVE

Women Only:

( ) Are taking a Birth control pill ( ) Have you reached Menopause ( ) Pregnant or nursing

Do You Take Or Have You Ever Taken:

( ) Tobacco in any form ( ) Recreation Drugs

Please List All Allergies: _____

Please list any medications, vitamins and herbal supplements you are currently taking:

_____

Do you have or have you ever had any other diseases or medical problems not listed on this form. If yes please explain: _____

Have you ever been told by a physician or dentist that you need pre-medication prior to any dental treatment? YES NO
If yes please explain: _____

DENTAL HEALTH HISTORY

How long since your last dental visit? _____

Is keeping your teeth important to you? YES NO

Have You Experienced Any Of The Following?

( ) Bleeding gums
( ) Bad breathe or sour taste in mouth
( ) Soreness in jaw
( ) Head or mouth injury
( ) Difficulty opening wide
( ) Clicking or popping of jaw
( ) Did you ever wear braces?
( ) Food catching between teeth
( ) Oral surgery of any kind
( ) Pain around ears, eyes face
( ) Sensitivity to hot / cold
( ) Stiff neck muscles

Does having dental treatment make you nervous or afraid?
If yes what specific things bother you? _____

If you could change anything about your smile which of the following would you want?

( ) Whiter
( ) Remove stains / spots on teeth
( ) Replace missing teeth
( ) Replace old fillings or crowns
( ) Straighter
( ) Repair chipped
( ) Close spaces
( ) Snoring

To the best of my knowledge all of the preceding answers and information are true, complete and accurate. I understand that this information is held in the strictest confidence and it is my responsibility to inform the office of any changes to medical or insurance status. I authorize the dental office to perform any procedures that may be needed during diagnosis and treatment. I, the undersigned, clearly understand all policies mentioned above. I understand and agree to pay all fees associated with my dental treatment. **I understand that 2 business days' notice must be given to change an appointment with the clinic or a charge may apply**. I give permission to share my personal and insurance information pertaining to my medical and dental history with other dental specialist that are involved in my care and wellbeing.

Patient Signature: _____Date:_____