Viva Dental Studio
#10-207 Fairmont Drive | Saskatoon | SK | S7M 5B8 | Phone: 306-668-1993

New Patient Intake Form

Cancellation Requirement: appointment times are booked exclusively for you, therefore 48 business hours' notice is required for any change or cancellation.

Personal Information

Name: _____ Birth Date: _____ □ Male □ Female □ Married □ Single □ Other

Address: _____ Postal Code: _____ SK. Health Card # _____

_____ Phone numbers: HM: _____ WK: _____

Cell: _____ Email Address: _____ receipts will be emailed.

Employer: _____ Position: _____ Dental Insurance: □ Yes □ No

Emergency Contact: _____ Phone number: _____

Name of spouse/parent (if under 18) _____ How did you hear of our office? _____

Dental Insurance:

Primary

Insurance company name: _____ Group # _____ Certificate # _____ Div #_____

Name of policy holder: _____ Birth Date: _____ Yearly maximum: _____

Secondary

Insurance company name: _____ Group # _____ Certificate # _____ Div # _____

Name of policy holder: _____ Birth Date: _____Yearly maximum: _____

Supplementary Health Benefits □ Yes □ No

First Canadian Health □ Yes □ No. Status number: _____

Dental History

Reason for today's visit _____ previous dentist _____ Date of last

Check-up/cleaning _____. How often do you brush? _____ Floss? _____

Are you nervous about dental treatment? □ Yes □ No

Have you ever had any complications with previous dental treatment? □ Yes □ No (if yes _____)

Are you having any concerns at this time? □ Yes □ No (if yes _____).

On a scale of 1 – 10 how satisfied are you with how your teeth look? _____

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Are you interested in Whitening your smile? □ Yes □ No

Do you ever experience any of the following?

□ Bad Breath □ Sore gums □ bleeding gums □ clicking or popping jaw □ space or crooked teeth □ grinding teeth

□ Missing teeth □ broken fillings □ sensitive teeth □ headaches □ neck pain □ strong gag reflex □ loose teeth

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Medical History

Are you currently in good health □ Yes □ No (if no) _____

Do you smoke or chew tobacco? Yes □ No

Are you taking any type of medication at time? □ Yes □ No

(if yes please list _____

_____)

WOMEN ONLY Are you pregnant □ Yes □ No (If yes due date) _____

Are you currently nursing? □ Yes □ No

Birth control pill? □ Yes □ No

Have you ever had any of the following diseases or medical problems?

□ Heart Problems □ Chest pain □ Heart murmur □ High/low blood pressure □ Rheumatic fever □ Scarlet Fever □ Ulcers

□ Arthritis □ Stroke □ Artificial joints □ Kidney problems □ Diabetes (type 1 or 2) □ Thyroid problems □ Glaucoma

□ Emphysema □ Cancer □ Tuberculosis □ Swollen ankles □ Psychiatric disorder □ Hemophilia □ Liver disease

□ Difficulty breathing □ Neurological disorders □ Drug/alcohol abuse □ Asthma Hay Fever □ Sinus Problems □ Bruise easily

□ Chemotherapy □ Hepatitis □A □B □C □ Venereal disease □ AIDS/HIV positive □ Fetal alcohol syndrome

□ Abnormal bleeding □ Fainting/dizzy spells □ Nervous/anxious □ Epilepsy/seizures

Anything else that was not listed _____

Are you allergic to any of the following?

□ Local anesthetic □ Codeine □ Penicillin or other antibiotics □ Sulfa drugs □ any metals □ Barbiturates □ Latex rubber

□ Iodine □ any other not listed _____

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I hereby consent to allow all necessary dental procedures and services to be performed. This may include x-rays and or dental freezing. I understand there are limitations with certain procedures and in some instances, complications may occur. I certify that I have read and understood the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If I ever have changes in my health I will inform the Dr. at my next appointment without fail.

Signature of patient or guardian: _____ Date: _____

Patient Name: _____ Date: _____

With the introduction of the new Health Privacy Act and the diversity of dental benefit packages more dentists are <u>not</u> accepting insurance as payment. We would like to be able to continue to offer our new and existing patients flexibility in paying for dental treatment with the following options.

1. □ Fee For Service:

This option allows you to be in control of your insurance benefits by paying in full at each appointment for treatment and being reimbursed directly by your insurance company. This will enable you to keep personal records of all dental transactions, all insurance reimbursements, track maximum allowable benefits and you will be more aware of what your plan does and does not cover. You will not have to come in to pay outstanding balances, or receive possible refunds. Monies to insurance subscribers are generally received within two weeks when submitted electronically.

2. □ VIP Express Checkout:

Our VIP Express Checkout Program allows us to continue to offer you the convenience of using your insurance plan as a form of direct payment. Please complete the information below. It will be kept confidential and used only under the agreed terms.

<u>Credit Card Authorization and Consent Form</u>

I, _____ hereby authorized Viva Dental Studio to charge

my credit card for any balance of account after insurance payment.

Type of Card: □ Visa □ MasterCard □ AMEX

Credit Card Number ends in: _____ Expiration Date: _____

Name of Cardholder: _____

Credit Card Billing Address: _____

_____

Authorized Signature of Cardholder: _____

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Signing this, I acknowledge the charges and assume full responsibility for said charges and agree to honour and abide by the terms of payment.

Submit Form

If the submit button above doesn't work, save this file to your device and then attach it to an email addressed to **appointments@vivadentalstudio.ca**

For desktop computers, click the down arrow icon at the top-right marked "download"

For iPhones and iPads, click the share icon at the bottom-centre and then select "Mail"

For Android devices, click the menu button and select "send file"