New Patient Information

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you?____

ABOUT YOU

Name: __________________________________I prefer to be called:________________ [ ] Male [ ] Female

Birth date: _____(Year)/_____(Month)/_____(Day)   Age: _____

Home Address: ____

City____Prov____Postal Code________________

Home Phone:(____)_____________Work: (____) ___________ ext. ___ Cell: (____) ________________

E-mail Address: ____

Employer: __________________________________ Occupation: _______________________

DENTAL INSURANCE INFORMATION

Primary Insurance

InsuranceCo Name:______________________Phone:(____)_________Group/Policy#:___________________

Insured'sName:___________________________Insured'sBirthdate:___/___/___Relation:_______________
D M YR

ID/Certificate or Employee#_____________________Insured's Employer:______________________________

INCASE OF AN EMERGENCY, WE SHOULD NOTIFY

Name: __________________________________ Relationship: ______________________________

Day-time Phone #: ___________________________

Name of Medical Family Doctor: ___________________Phone or Address: _________________________

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APPOINTMENT POLICY

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us 1 business day or **24 hours notice** if they cannot keep an appointment. Late notice or missed appointments may be subject to a minimum $60 charge.

FINANCIAL POLICY

Payment in full is due the day of treatment, or on upon the start of major treatment. We use Ontario Dental Association fee guide.

Payment Options

1. For your convenience we accept Cash, Debit, Visa, Mastercard.
2. We also offer short-term financing options but interest charges will apply. All arrangements must be made in advance and are subject to an approval process.

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service. Therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. **You are ultimately responsible for all costs incurred regardless of what your dental insurance covers!**

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Hardik Patel. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Smiles by Dr. Patel to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Hardik Patel.

I understand and will comply with office **Appointment Policy**.
I understand and will comply with the office **Financial Policy**.
I understand and agree to the **General Consent to Treatment**.
I authorize the **Release of Information**.
I authorize the **Assignment of Insurance Benefits.**

X ____ Date _________________________

Signature of patient, parent or guardian