Altitude
DENTAL

PATIENT INFORMATION

PATIENT NAME: ____________________ BIRTHDATE: __________ GENDER: ______
LAST FIRST MIDDLE INITIAL ("PREFERRED NAME") DD / MM / YYYY

ADDRESS: ____________________
NUMBER AND STREET (APARTMENT #) CITY PROVINCE POSTAL CODE

PHONE: ______ **WORK:** ______ **CELL:** ______ **EMAIL:** ______
TEXT REMINDERS? YES / NO **EMAIL REMINDERS? YES / NO**

Whom can we thank for referring you to our practice? ____________________

HEALTH INFORMATION

When was your last dental visit? ______ Reason for this visit: ______

Have you ever had complications following dental treatment?
☐ Yes ☐ No If yes, please explain: ______

Have you been admitted to a hospital or needed emergency care during the past two years?
☐ Yes ☐ No If yes, please explain: ______

Are you currently under the care of a medical or dental specialist?
☐ Yes ☐ No If yes, please explain: ______

Do you have any health problems that need further clarification?
☐ Yes ☐ No If yes, please explain: ______

Have you had any of the following? Please check/circle those that apply.

☐ Allergies: ______________
____
☐ Anemia
☐ Arthritis/Rheumatism
☐ Asthma
☐ Blood Disease
☐ Blood Pressure (High/Low)
☐ Cancer/Tumor
☐ Cardiac Pacemaker
☐ Diabetes (Type 1/Type 2)
☐ Dizziness
☐ Epilepsy
☐ Fibromyalgia
☐ Glaucoma
☐ Head Injuries
☐ Heart Attack/Stroke
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis: ___________
☐ HIV+/AIDS
☐ Immune Disorders
☐ Kidney Disease
☐ Joint Replacement/Artificial Joints
☐ Jaundice
☐ Leukemia
☐ Liver Disease
☐ Lung Disease
☐ Mental Disorders
☐ Multiple Sclerosis
☐ Nervous Disorders
☐ Radiation Therapy
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Stomach Problems
☐ STI: ____________
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Other: ______________
____

IF FEMALE, PLEASE ANSWER
Taking birth control? ☐ Yes ☐ No
Currently pregnant? ☐ Yes ☐ No
If yes, number of weeks: ____________
Are you nursing? ☐ Yes ☐ No

CONSENT FOR TREATMENT

I authorize Dr. Daniel Vaida, or whomever he may designate, to perform diagnostic procedures and dental treatment as may be necessary for my best health and proper dental care.

I understand that treatment plans (discussed or printed) for my self (or my child), with Dr. Vaida or a member of his health team, are considered as part of the consent for treatment.

I understand that dentistry is not an exact science and on occasion treatment may need to be altered. I authorize Dr. Vaida and his health team to perform changes to my treatment if the change is within a reasonable amount (ie: a larger cavity). If the procedure changes or additional treatment is required, Dr. Vaida or a health team member will discuss the options with me. At that point I can decide the treatment option to proceed with.

____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN FOR THOSE UNDER 18 YEARS) **DATE**

Altitude DENTAL

INSURANCE INFORMATION

Are you covered by dental insurance? ☐ Yes ☐ No

❶ PRIMARY PLAN

NAME OF INSURED: ______ BIRTHDATE: ______ SAME AS PATIENT? ☐ YES

LAST FIRST MIDDLE INITIAL DD / MM / YYYY

ADDRESS: ______ SAME AS PATIENT? ☐ YES

NUMBER AND STREET (APARTMENT #) CITY PROVINCE POSTAL CODE

INSURANCE CARRIER: ______ **GROUP/PLAN #** ______ **ID/CERTIFICATE #** ______

Patient's relationship to the insured? ☐ Self ☐ Spouse ☐ Child ☐ Other

❷ SECONDARY PLAN

NAME OF INSURED: ______ BIRTHDATE: ______

LAST FIRST MIDDLE INITIAL DD / MM / YYYY

ADDRESS: ______

NUMBER AND STREET (APARTMENT #) CITY PROVINCE POSTAL CODE

INSURANCE CARRIER: ______ **GROUP/PLAN #** ______ **ID/CERTIFICATE #** ______

Patient's relationship to the insured? ☐ Self ☐ Spouse ☐ Child ☐ Other

FINANCIAL CONSENT

- Financial arrangements must be made prior to the start of treatment.
- If you do not have insurance coverage, payment is due in full at the date of services rendered unless in the case of a financial arrangement.
- Our office does not guarantee insurance coverage for treatment you receive from our practice. It is the patients' responsibility to be aware of their coverage details. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. **Your patient co-payment is due at each visit.**
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.
- Provincial fee guides are updated every February 1st, and can alter the cost of treatment.

I authorize and release information and payment of my dental benefits directly to the practice. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Altitude Dental may use my heath care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

I have read and fully understand my financial options and obligations. I understand that in the event my account becomes delinquent I will be responsible for any collections, legal fees and any other charges incurred to collect this account.

I authorize Dr. Daniel Vaida or his assignee to contact me though mail, e-mail, or phone to discuss financial matters regarding my account.

______

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN FOR THOSE UNDER 18 YEARS) **DATE**