DENTAL HYGIENE CARE
ANGELICA VIILEGAS
INDEPENDENT REGISTERED DENTAL HYGIRNIST

180 Westheights Drive
Kitchener, Ontario N2N 1J9
Phone: (519)576-4537/(519)5SMILES

Mr.____ Miss.____ Ms.____ Mrs.____ **Today's Date: MM ___/DD____/YR_____**
Full Name: ____________________ D.O.B: MM ____/DD____/YR______ Age: ____
Home Address: ____________________ Apt #: _______________
City: ______________ Province: ______________ Postal Code: ______________
Home Tel: ______________ Cellphone: ______________ Business Tel: ______________
Email Address: ____________________
Occupation: ______________ Employer: ______________
Work Address: ____________________ Work Tel: ______________
Family Dr: ______________ Telephone: ______________ Address: ______________

How did you hear about Angel's Smiles: Family: ____ Friend: ___ YP: ____ Co-worker:______ other: ______________

Insurance Information

Is this patient covered by insurance? Yes: ____ No: ______
Primary insurance Subscriber name: ____________________ D.O.B: MM ____/DD____/YR______
Patient relationship to subscriber: Self: ____ Spouse: _____ Child: ____ other___________
Name of secondary insurance (if applicable) ____________________
Subscriber name: ______________ Policy #:______________ Cert #: ______________
Employer: ______________ Occupation: ______________ Work Tel: ______________

Emergency Contact: ______________ Tel: ______________ Relationship: ______________

*OFFICE POLICY REGARDING INSURANCE: Your dental insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. The responsibility of payment ultimately lies with the patient, not the insurance company. As a courtesy, we will file your claim on your behalf. I understand that **I am required to pay my "Estimated Patient Portion" and any deductible** due, to **Angel'Smiles** at the time of my visit. Failure to provide our office with all the information necessary to file your insurance claim will require full payment at the time of service. **Any portion of treatment that the insurance does not cover is the patient's responsibility.** A statement will be sent to the patient for any balance which is not paid by the insurance company. I hereby authorize the release of any dental information that is needed to file my insurance. I consent to treatment for myself/family under 18 years old. I have read the above statements and understand that **I AM RESPONSIBLE FOR PAYMENT IN FULL AFTER (30) DAYS OF MY TREATMENT, REGARDLESS OF ANY DELAY IN PAYMENT(S) BY MY INSURANCE COMPANY.***

______________________________ ______________________________
Signature Date: **MM /DD/YYYY**

The above information is true to the best of my knowledge. I authorize my insurance benefits to pay directly to the dental hygienist/Angel'Smiles. **I understand that I am financially responsible for any balance**. I also authorize my insurance company to release any information required to process my claims.

______________________________ ______________________________
Patient/Guardian Signature **Date: MM /DD/YYYY**

HEALTH HISTORY

Have you ever had an unfavorable reaction following Dental treatment? Yes: ___ No: _____

LIST OF ALLERGIES: _________________________________

Have you ever had excessive bleeding requiring special Treatment? Yes: ___ No: ____

Female patients: are you or could you be pregnant or Nursing? Yes: _____ No: _____ If pregnant mm: ______

LIST OF MEDICATION AND RESON FOR TAKING?

____

Do you have or have you had any other or medical problems

____

Check any of the following which you have or had:

☐ Heart trouble/angina	☐ Artificial valve, joint or prosthesis	☐ Osteoporosis	☐ Sickle cell disease
☐ Heart murmur	☐ Anemia	☐ Kidney disease	☐ Liver disease
☐ Asthma	☐ Rheumatic fever	☐ Fainting spells	☐ Thyroid disease
☐ Diabetes	☐ Lupus	☐ Sinus problems	☐ Alcoholism
☐ Arthritis	☐ Nervous disorders	☐ Neck injury	☐ Cardiac Pacemaker
☐ Congenital Heart defect	☐ Cortisone treatment	☐ Psychiatric Treatment	☐ Mitral valve prolapse
☐ Stroke	☐ Cancer treatment	☐ Addiction	☐ Blood transfusions
☐ Hemophilia	☐ Migraine/Headache	☐ TMJ Problems	☐ Tuberculosis TB
☐ Epilepsy	☐ Emphysema	☐ HIV & or AIDS	☐ High blood pressure
☐ Glaucoma	☐ Hepatitis A-B.C OR Jaundice	☐ Stomach ulcer	☐ Smoker? Y N ______
☐ Venereal Disease			

DENTAL HISTORY

Do you have any dental concerns? YES ___ NO____. If Yes, specify:____

Date of last dental hygiene visit ____

How often do you: Brush? ____________ Floss? _____________

-Are you pleased with the appearance of your teeth? YES___ NO____

-Are you currently experience any dental discomfort? YES___ NO____

-Is any part of your mouth sensitive to the following : ___Hot ___Cold___ Biting ___Sweets __ Other__________________

-Do you any implants? ____ Root Canal Treatments? _______ Crowns? ________ Orthodontics? _________

Consent to Treatment

I certify that I have read, understood and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding my medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the Dental Hygienist to perform necessary diagnostic procedures and treatment as required to achieve the proper level of oral hygiene treatment-care and to share my information with any dental practitioner if needed. I understand that I am financially responsible for the dental hygiene services provided even if my insurance coverage may not be inclusive.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE DENTAL HYGIENE SERVICES PROVIDED EVEN IF MY INSURANCE COVERAGE MAY NOT BE INCLUSIVE.

_______________________________________ _______________________________

Signature: Patient/Parent/guardian. ***MM/DD/YYYY***