

Patient's LAST Name		M / F	Given Names (First and Middle)		Home Tel #	Cellular #
Date of Birth Day/ Month/ Year		School Attending		Emergency Contact (Telephone Number & Relationship)		
MOTHER's (Full Given Name/Guardian)		Date of Birth Day/ Month/ Year		Social Insurance #		Cellular #
Apt - Unit	Address			City	Postal Code	
Mother's Employer & Occupation			Business telephone #		Address same as child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
FATHER's (Full Given Name/Guardian)		Date of Birth Day/ Month/ Year		Social Insurance #		Cellular #
Apt - Unit	Address			City	Postal Code	
Father's Employer & Occupation			Business telephone #		Address same as child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient's Previous DENTIST Dr.		Last Dental Visit?		Pharmacy		Telephone #
Patient's PHYSICIAN'S Name Dr.		Telephone #		Other Health Care Provider(s)		
How did you find out about this office? (Circle All That Apply)				Patient's reason for today's visit:		
Family Member Friend Sign Out Front Newsletter Radio Ad				_____		
YellowPages Inside YellowPages Backcover Other:				_____		

All information gathered is considered confidential and enables us to provide this child with the best possible dental care. Do we have your permission to contact you / patient via telephone or email? **YES YES- Only _____ NO**

YOUR CHILDS APPOINTMENT time given is reserved especially for them. Consider their appointment confirmed. Respectfully, if they are unable to keep the appointment we require two full business days notice.

Failure to extend this courtesy may result in a fee.

Initials of Patient/Parent _____/_____

BENEFIT INFORMATION				
Benefits Belong To (Person)	Primary Benefits (Carrier)	Primary Group #	Primary Certificate or ID #	Division #
Benefits Belong To (Person)	Secondary Benefits (Carrier)	Secondary Group #	Secondary Certificate or ID #	Division #

It is the parent's responsibility to inform Cosmo Dental Centre immediately of any changes.

EDI	I authorize release, to my benefit company, plan administrator, the information contained in claims submitted electronically.
	Signature: _____

Account/Payment OPTIONS, Please indicate the following:

- We do not have benefits/ We have benefits. However, We will pay in full per visit and recover any amounts payable from a benefit provider. (Non-Assignment)
- Our dental benefits pay Cosmo Dental Centre for those procedures that are covered by a benefits provider. We will pay our portion, percentage and/or uncovered care at the conclusion of each visit.
Note: Our benefits contract must permit us to choose this option. (Assignment)

Payment from our benefits, Primary / Secondary or other, for services rendered must be received by Cosmo Dental Centre within 30 days of treatment. This would require any and all relevant claim forms signed and returned to Cosmo Dental Centre within 3 business days. Cosmo Dental Centre provides a 24-hour mailbox for our convenience.

I am obligated to clear any balances remaining after those 30 days.

A service charge of 2.0% per month will be assessed on all overdue accounts (24% per annum).

I am aware Cosmo Dental Centre is NOT responsible for what is paid or not paid for by our benefit plans, they remain first and foremost one of my primary Health Care Providers. I will pay according to an agreed upon payment schedule.

I understand that I am financially responsible to Cosmo Dental Centre for the dental services provided.

Date: _____, 20 _____

Parent's Signature: _____

Questions in regards to Patient (not parent)

Is a physician or other healthcare professionals treating you for any conditions? **YES NO Not sure/Maybe**
 (Details:)

When was your last medical checkup? _____
 Has there been any change in your general health in the past year? **YES NO Not sure/Maybe**
 (Details:)

Taking any prescription/non-prescription medications or herbal supplement? **YES NO Not sure/Maybe**
 (Please list)

ALLERGY? Latex products, Environmental, Foods, Dyes. **YES NO Not sure/Maybe**

ALLERGY? Medications, Antibiotics, Pain medications, Other. **YES NO Not sure/Maybe**

(Please list) _____
 Ever had a peculiar or adverse reaction to medications, or injections? **YES NO Not sure/Maybe**
 (Details:)

Do you have or have you ever had...
 Blood pressure/Other Heart concerns? **YES NO Not sure/Maybe**

Please check all that apply,
 Heart murmur Rheumatic/Scarlet Fever Chest pain/Angina Heart attack Pacemaker Mitral valve prolapse

(Details:)
 Replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (ie.congenital heart disease) **YES NO Not sure/Maybe**
 (Details:)

Do you have a prosthetic or artificial joint? **YES NO Not sure/Maybe**
 (Details:)

Pre medication required for dental treatment? **YES NO Not sure/Maybe**

Any conditions or therapies that could affect your immune system? **YES NO Not sure/Maybe**

Please check all that apply,
 Leukemia Radiotherapy Chemotherapy HIV positive AIDS Other _____

Asthma, Breathing problems, Shortness of breath or Lung disease? **YES NO Not sure/Maybe**
 (Details:)

Hepatitis Type _____, Jaundice or Liver disease? **YES NO Not sure/Maybe**
 (Details:)

Blood disorders or bleeding concerns? **YES NO Not sure/Maybe**
 (Details:)

Diabetes? Type _____ **YES NO Not sure/Maybe**
 (Details:)

Epilepsy or seizures? **YES NO Not sure/Maybe**
 (Details:)

Stomach, Intestinal issues or ulcers? **YES NO Not sure/Maybe**
 (Details:)

Experienced Fainting or dizzy spells? **YES NO Not sure/Maybe**
 (Details:)

Any Type of Surgery, Hospitalization, Serious illness? **YES NO Not sure/Maybe**
 (Details:)

Ever had any of the following? Please check all that apply,
 Cancer Stroke Tuberculosis Steroid Therapy Arthritis Thyroid Disease
 Drug/Alcohol Addiction Kidney disease Osteoporosis Medications (e.g. Fosamax, Actonel)

(Details:)
 Any Conditions or diseases not listed above that you have or have had? **YES NO Not sure/Maybe**
 (Details:)

Any medical concerns that run in your family? **YES NO Not sure/Maybe**
 (Details:)

Significant weight changes recently? **UP/DOWN ___ lbs in ___ months**
 (Details:)

Daily Quantities for the following: Chew Gum? **YES NO** Quantity-___ Water? **YES NO** Quantity-___
 Pop? **YES NO** Quantity-___ Tea? **YES NO** Quantity-___ Coffee? **YES NO** Quantity-___ Juice? **YES NO** Quantity-___
 Milk? **YES NO** Quantity-___ Alcohol **YES NO** Quantity Beer -___ Spirits___ Wine___

Smoke? Chew Tobacco? **YES NO** Quantity-___ How Long:___ Considering Quitting? **YES NO Not sure/Maybe**

Women Only: Currently Breastfeeding? **YES NO** Pregnant? **YES NO Not sure/Maybe** Due Date: _____

I certify that I have read, understood and accurately completed this health questionnaire 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 receive answers regarding any medical and dental histories. I consent to current and previous dentists / physician and other health care providers being contacted regarding current and past conditions. I authorize the dentist to perform necessary diagnostic procedures and treatment as required to achieve the proper level of dental care.

Date: _____, 20____ Signature: _____

Reviewed by: _____ / _____ on _____