COSMO Dental Centre

ADULT Health Questionnaire

PID# _____ Alt.ID _____

Patient's LAST Name	Mr. Ms. Mrs. Dr.	Given Names (First and Middle)	Please provide numbers where we can call & message you. Circle preferred number.
Apt -Unit / Address		City / Postal Code	Home Tel. #
Date of Birth Day/ Month/ Year	Marital Status	E-Mail Address	Cellular #
Social Insurance #	Government photo ID ☐ copied		Business Tel. & Ext .
Occupation / Position	Employer	Emergency Contact	Emergency Contact Tel. #

Spouse/Partner's LAST Name	Mr. Ms. Mrs. Dr.	Given Name (First and Middle)	Cellular #
Date of Birth Day/ Month/ Year	Social Insurance #	Business Telephone & Extension	
Occupation / Position	Employer	Business Address	

Previous DENTIST Dr.	Last Dental Visit?	PHARMACY	Telephone #
PHYSICIAN'S Name Dr.	Telephone #	Other Health Care Provider(s)	

How did you find out about this office? (Circle All That Apply)
Family Member Friend Sign Out Front Newsletter Radio Ad
YellowPages (*Inside*) YellowPages (*Backcover*) Other:

Reason for today's visit:
_____
_____

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 patient's responsibility to inform Cosmo Dental Centre immediately of any changes.

Please answer completely:
Are you under any treatment by your physician? YES NO _____
Are you taking any prescription or non-prescription medications? YES NO _____

Do you have or have you ever had…

Any serious illnesses YES NO _____
Any serious surgeries YES NO _____
Heart murmur YES NO _____
Rheumatic / Scarlet Fever YES NO _____
Blood pressure / other Heart concerns YES NO _____
Blood / bleeding disorders YES NO _____
Epilepsy or seizures YES NO _____
TB (Tuberculosis) YES NO _____
Lung / breathing problems YES NO _____
Liver / kidney problems YES NO _____
Hepatitis A B C YES NO _____
Diabetes YES NO _____

Stomach or intestinal problems YES NO _____
Have you experienced fainting or dizzy spells YES NO _____
Do you have any environmental / food allergies? YES NO _____
ALLERGIES to antibiotics, or pain medications? YES NO _____
(specify) _____
Have you been warned against / had trouble with any medications, including, local (freezing) or general anaesthetic? YES NO _____
Have you had any significant weight changes recently YES NO_____
Ever had or been tested positive for any immunocompromising diseases? YES NO _____

Pop Y N How Many _____ Juice/Milk Y N How Many _____
Tea/Coffee Y N How Many _____ Chew gum Y N How Often _____
Smoke Y N How Much _____ Alcohol Y N How Often _____

Is there anything else we should know about your health?
_____
_____

WOMEN ONLY: **Currently Breastfeeding?** YES NO **Pregnant?** YES NO Not sure/Maybe **Due date:**_____

Date: _____, 20_____ **Signature:** X _____

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

All information gathered is considered confidential and enables us to provide you with the best possible dental care.
By providing us with phone numbers & email, you give us your consent to contact, email or message.

Initials of Patient **X** _____

YOUR APPOINTMENT time given is reserved especially for you. Consider your appointment confirmed. Respectfully, if you 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 **X** _____

Account/Payment OPTIONS, Please indicate the following:

☐ I do not have benefits/ I have benefits. However,
I will pay in full per visit and recover any amounts payable from a benefit provider. (Non-Assignment)

☐ My dental benefits pay Cosmo Dental Centre for those procedures that are covered by a benefits provider.
I will pay my portion, percentage and/or uncovered care at the conclusion of each visit.
Note: My benefit contract must permit me to choose this option. (Assignment)

Payment from my 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 my 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 my benefit plan, 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.

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 my current and previous dentists / physician and other health care providers being contacted regarding my 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: X _____

Reviewed by:_____/_____on _____

OFFICE USE ONLY

Date/Initials **LAST Comp ex… Pan…. Cleaning….. Smile…. Reason Left…. Team/Hob/Int… Like/Dislike… Family**

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