

# warmland dental

Dr. Tom Roozendaal Inc.

## Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Last First MI  
 Male  Female Personal Health # \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Preferred appointment times:  Morning  Afternoon  Evening  Any Time  M  T  W  T  F

Address: \_\_\_\_\_  
Apt # Street# Street City Postal Code

## Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |                                              |                                              |                                               |                                             |
|----------------------------------------------|----------------------------------------------|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Allergies _____     | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tobacco Habit      |
| _____                                        | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Growths             | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Hay Fever           | Due date: _____                               | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      | OTHER:                                      |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Rheumatism           | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath  | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Sinus Problems       |                                             |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stomach Problems     |                                             |

• Have you ever had any 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 now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Are you currently taking any medications?  Yes  No  
If yes, please list: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

Address: \_\_\_\_\_  
Apt # Street# Street City Postal Code

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Apt # Street# Street City Postal Code

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Apt # Street# Street City Postal Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Province Postal Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Apt # Street# Street City Postal Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Apt # Street# Street City Postal Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient minus the percentage coverage offered by the insurance plan. Fees not covered by the insurance plan are payable on the day of service. This office will prepare the patients insurance forms, make collections from insurance companies and will credit any such collections to the patient's account. However, if the insurance information provided to us is incorrect this office cannot be responsible for outstanding balances. Any outstanding balances are the sole responsibility of the patient. As we cannot control laboratory fees, these charges sometimes are above what many dental plans will cover and will be charged to the patient.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I understand that the information gathered on this form and in subsequent visits may be used to contact me at my home or work to discuss matters related to this form, discuss treatment needs or outcomes, and correspond with other health care providers who may participate in my treatment. Digital photos and x-rays may be used for educational purposes or presentations while guaranteeing my anonymity. My personal information will not be given to anyone for any other purpose.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_