GENERAL RELEASE

- I authorize the dentist to perform diagnostic procedures and treatments that may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.
- I authorize the release of any information concerning my (or my child's name) healthcare, advice and treatment to another dentist
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance company may pay less then the actual bill for services; I understand I am financially responsible for payments in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.
- I authorize the setting up of my dental file, its follow-up, as well s my registration on the recall list(s) of the treating dentist(s)
- I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it.
- I attest to the accuracy of the information on this registration form.

_____ _____

Signature of Patient or Parent/Guardian Date

MEDICAL/DENTAL INFORMED CONSENT

I, the undersigned, certify that I have provided, to the best of my knowledge, an accurate and complete medical & dental history and have not knowing omitted any information. I consent to my dentist obtaining from other practitioners who are currently treating me or have treated me, such further information as maybe necessary for providing me with proper dental treatment and care. I hereby promise to inform my dentist of any changes to my heath status.

_____ _____

Signature of Patient or Parent/Guardian Date

SIGNATURE ON FILE

- I authorize release to my insuring company(s) plan administrator(s) the information contained in claims submitted electronically.
- I hereby assign my benefits payable from claims submitted electronically to Dr. Archibald and authorize payment directly to him.

_____ _____

Signature of Patient or Parent/Guardian Date

Patient Name _____ Date of Birth _____

Family Physician _____ Office Phone _____

Have you had a medical exam in the last 12 months? □ Yes □ No DOCTOR COMMENTS
Date of last exam _____
Have there been any changes in your general health within the past year? □ Yes □ No
Have you ever been hospitalized? □ Yes □ No
Are you now receiving medical treatment? □ Yes □ No
Are you presently taking any form of medications? □ Yes □ No
Have you ever been diagnosed or treated for Cancer? □ Yes □ No
Have you ever had heart problems or heart disease? □ Yes □ No
Do you or have you ever taken illegal drugs? □ Yes □ No
Have you ever taken diet pills? □ Yes □ No
Do you smoke or chew tobacco? □ Yes □ No
Would you like to speak to the dentist privately? □ Yes □ No

Are you allergic to or have you had reactions to:

Local Anesthetics	□ Yes □ No	Antibiotics	□ Yes □ No
Sulpha Drugs	□ Yes □ No	Sedatives	□ Yes □ No
Iodine	□ Yes □ No	Asprin/Codeine	□ Yes □ No
Metals	□ Yes □ No	Latex Rubber	□ Yes □ No
Specific Foods	□ Yes □ No	Flavors (e.g. Mint)	□ Yes □ No

Other _____

WOMEN ONLY:

Are you pregnant or think you are pregnant? □ Yes □ No
Are you nursing? □ Yes □ No
Are you taking oral contraceptives? □ Yes □ No

Have you ever had/or been treated for:

High Blood Pressure	□ Yes □ No	Tonsillitis/Strep Throat	□ Yes □ No
Low Blood Pressure	□ Yes □ No	Prolonged Bleeding	□ Yes □ No
Swollen Ankles/Feet/Hands	□ Yes □ No	Hemophilia	□ Yes □ No
Cortisone Treatment	□ Yes □ No	AIDS/HIV infection	□ Yes □ No
Kidney Problems	□ Yes □ No	Sexually Transmitted Disease	□ Yes □ No
Diabetes	□ Yes □ No	Fainting/Dizzy Spells	□ Yes □ No
Contact Lenses	□ Yes □ No	Epilepsy/Seizures	□ Yes □ No
Glaucoma/Eye Problems	□ Yes □ No	Frequently Tired	□ Yes □ No
Asthma	□ Yes □ No	Anxiety/Nervousness	□ Yes □ No
Shortness of Breath	□ Yes □ No	Stomach Troubles/Ulcers	□ Yes □ No
Persistent Cough	□ Yes □ No	Drug Addiction	□ Yes □ No
Sinus Troubles/ Colds	□ Yes □ No	Alcohol Dependence	□ Yes □ No
Cold Sores/Fever Blisters	□ Yes □ No	Psychiatric Care	□ Yes □ No
Tuberculosis	□ Yes □ No	Recent Weight Loss/Gain	□ Yes □ No
Emphysema /Bronchitis	□ Yes □ No	Skin Problems	□ Yes □ No
Frequent Headaches	□ Yes □ No	Frequent Earaches	□ Yes □ No
Allergies/Hay fever	□ Yes □ No	Hives/Skin Rash	□ Yes □ No

Eating Disorders	□ Yes	□ No	Rheumatic/Scarlet Fever	□ Yes	□ No
Liver Problems	□ Yes	□ No	Hepatitis A/B/C	□ Yes	□ No
Arthritis	□ Yes	□ No	Organ Transplant	□ Yes	□ No
Back Problems	□ Yes	□ No	Artificial Joints/Implants	□ Yes	□ No
Anemia	□ Yes	□ No	Blood Transfusion	□ Yes	□ No
Excessive Bruising	□ Yes	□ No			

I CERTIFY THAT THE ABOVE INFORMATION IS COMLETE AND ACCURATE

Patient or Parent/Guardian Signature_____ Date _____

Treating Dentist's Signature _____ Date_____

Initial Health Status:

_____
_____
_____
_____
_____

Initial Medication List

_____
_____
_____
_____
_____

Patient Name _____
(Include Initial)

Patient Information

Marital Status
Single □ Married □ Common Law □ Other □
Spouse/Partner's Name _____
Address_____
City _____Postal Code_____
Occupation _____
Health Card No._____
Do you have family members or friends that are patients of this office?
No □ Yes □
Referred by _____

Contact Information

Home Phone (____) _____
Work Phone (____) _____
Cell Phone (____) _____
Email Address _____

Please indicate the best time to contact you for appointments:
Anytime of the day □ Days Only □ Evenings Only □
In case of an emergency, contact:
Name _____Relationship_____
Telephone (___) _____

Responsible Party

□ Self □ Spouse □ Other
If not self please complete the following:
Name _____
Address _____
City _____
Employer _____
Phone: Home_____ Work _____
Is this person currently a patient at our office? Yes □ No □

Adult □ Child □ Date of Birth _____

Dental Insurance (Primary Coverage)

Employee Name _____
Employee Date of Birth _____
Employer _____
Insurance Company_____
Address _____
_____

Telephone _____
Group or Policy No. _____
Certificate or ID No. _____

Dental Insurance (Additional Coverage)

Employee Name _____
Employee Date of Birth _____
Employer _____
Insurance Company _____
Address _____
_____
Telephone (___) _____
Group or Policy No. _____
Certificate of ID No. _____

Payment Information

Method of Payment:
Cash □ Cheque □ Credit Card □

Coverage:

Basic _____%	Ortho _____%
Major _____%	Endo _____%
Other _____%	Perio _____%

Maximum Coverage _____

Check up Frequency: Every _____ Months