NORTHSIDE DENTAL CLINIC

Dr. Amanda Frame
Dr. Holly MacPherson
Dr. Travis McLean
254 Main Street Fredericton NB
506-458-9477

PATIENT INFORMATION

Last Name: _____ First:_____ Mid Initial: ____ ☐M ☐F

Date of Birth (DD/MM/YYYY)_____Occupation: _____ Employer: _____

Home Address: _____

City: _____Province: _____ Postal Code: _____

Email: _____ Mobile Phone: _____

Pharmacy: _____ Secondary Phone: _____

Dental Insurance ☐**YES** ☐**NO** *If yes, please provide your dental insurance card*

MEDICAL HISTORY

Are you currently or have you been under the care of a physician during the last two years? ☐**YES** ☐**NO**

Conditions being treated: _____

Have you had any serious illness or surgeries? ☐**YES** ☐**NO** If yes, please list _____

Have you been hospitalized in the last two years? ☐**YES** ☐**NO**

Please check any of the following that you have had or have at present:

☐Heart Attack
☐Heart Condition
☐Angina
☐Pacemaker
☐High Blood Pressure
☐Osteoporosis Medications
☐Joint Replacement
☐Diabetes
☐Stroke
☐Seizures
☐Fainting
☐Lung Disease
☐AIDS (HIV Positive)
☐Bleeding Disorder
☐Hepatitis A B C
☐Cancer
☐Chemotherapy
☐Radiation

☐Other, please specify: _____

Have you had any abnormal bruising or bleeding with extractions, surgery or trauma? ☐**YES** ☐**NO**

Do you have any known allergies? ☐**YES** ☐**NO** If yes, please list: _____

Are you taking any medications? ☐**YES** ☐**NO** If yes, please list: _____

Have you had in the past or do you currently have any disease, condition or problem not listed above?

If yes, please specify:_____

WOMEN ONLY: Are you pregnant? ☐**YES** ☐**NO** Are you nursing? ☐**YES** ☐**NO**

PATIENT APPROVAL AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted pertinent information. I consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetic. I understand that any work needed will be fully discussed with me by the dentist prior to beginning treatment, including other treatment options. I understand that no treatment is always an option. I understand that I am personally responsible for payment at time of all dental services rendered even if my insurance coverage may not be all inclusive. I consent to my physician being contacted if necessary, as this information may be required for my dental care.

Please advise us in the future of any change in your medical history or any medications you may be taking.

Patient (Parent, Guardian) Signature: _____Date: _____

DENTAL HISTORY

When was your last dental visit? _____

How frequently did you see your dentist in the past? _____

Date of your last dental exam? _____ Any outstanding treatment? ☐**YES** ☐**NO**

How often do you brush your teeth? _____ Floss?_____

Are you aware of any lump, swelling or sores in your mouth? ☐**YES** ☐**NO**

Do you grind or clench your teeth? ☐**YES** ☐**NO**

Have you had any adverse reaction or complication to local anaesthetic (freezing)? ☐**YES** ☐**NO**

Have you had any serious trouble with any previous dental treatment? ☐**YES** ☐**NO**

If yes, please specify: _____

Are you tense or nervous during dental visits? ☐**YES** ☐**NO**

Have you had Ativan or Nitrous Oxide (laughing gas) for any dental treatment? ☐**YES** ☐**NO**

Do you currently experience any of the following?

☐Unsatisfactory dentures
☐Headache/Earache
☐Food wedging between teeth
☐Sensitive teeth
☐Problems flossing
☐Sore gums
☐Bad Breath
☐Bleeding gums
☐Clicking in jaw joints (TMJ)
☐Loose Teeth

Have you had any of the following?

☐Orthodontics / Braces
☐Periodontics / Gum Treatment
☐Endodontics / Root Canal
☐TMJ / Bite Problems
☐Bleaching
☐Crowns / Bridges / Veneers / Implants
☐Partial Dentures
☐Bite Plane / Night Guard

Insurance Agreement

Initial here:_____

We will direct bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. **Our dental office accepts no responsibility for any uncovered amounts, amounts over benefit maximums, limitations or plan restrictions, etc. Please bring your insurance breakdown of your dental benefits with you.** This will assist us in ensuring you get the most out of your plan. Full payment to our office remains your responsibility, regardless of what your insurance covers.

IMPORTANT: Please be advised that complete oral examinations (new patient exams) & x-ray coverage will be denied by your insurance if you have had this procedure completed at another dental office within the time limitations on your specific plan. Please check with your previous dental office to find out when your last visit was (including exams, recalls, x-rays and PAN.) You are responsible for payment in our office should this not be an eligible benefit with your coverage.

Cancellation Policy

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other patients as well.

Because we reserve time exclusively for you, we ask that you make every effort to keep your reserved appointment time. If you find that you cannot keep your scheduled visit**, we require a minimum of 48 hours to change your appointment. After 24 hours prior to your appointment, you will be subject to a $50 fee**. Advance notice allows our office to see other patients who may have been waiting to see us for necessary treatment. We thank you in advance for your consideration. As well, a no-show is when a patient misses an appointment without cancelling. We require confirmation for each scheduled visit, therefore if we are unable to confirm, the appointment will be cancelled by our office and be considered a missed appointment.

If cancellation is necessary, please call us at **(506) 458-9477.** You may leave a detailed voicemail message and we will return your call as soon as possible.

- Any missed appointment will incur a **$50 fee**.
- Future missed appointments will result in either only booking short notice or possible dismissal.

Patient (Parent, Guardian) Signature: _____Date: _____

Dentist Signature: _____Date: _____