Patient Chart **Therapeutic Alert:**_____

Last Name: _____ First Name:_____ M / F (circle) DOB: ____/____/____ (M/D/Y)

Address:_____ City_____ Prov._____ Postal code_____

Phone #:_____ Cell #:_____ Email:_____

Insurance Company: _____ Plan/Group:_____ I.D. #_____

Carecard #:_____ Marital Status: S / M / D / W / Com-L

How did you hear of us?: _____

Health History

Family Physician:_____ Phone #:_____

Do you have any pre-existing medical conditions:_____

Have you been hospitalized within last 2 years for: ___A Serious Illness ___Operation ___Accident

If so, for *what* and *when*:_____ _____

Are you pregnant? ____No/N/A ____ Yes How many months?_____

Do you smoke? _____ Recreationally ____ Medicinally ____No (if medicinally) *Indicate purpose*:

_____

____ Tobacco _____ Cigarettes _____ Cannabis _____ Vape

Medications

Current medications/drugs being taken?: ____Yes _____ N/A Any allergies to medications? Please specify.

___Yes ___No

If yes, please *indicate* what medication/drug and its *purpose:* Please indicate._____

_____

Do you suffer from any of the following?: (circle)

Jaw problems (locking/clicking/clenching) Lip biting Grinding of teeth Cheek/nail biting

Teeth sensitivity Headaches/migraines Mouth breathing Neck aches Muscle problems Bad breath

Heavy snoring

Dental History

When was the last time you've been to the dentist? _____ Dental Clinic:_____

Dentist Name:_____

Do you have any nervousness/inhibitions with seeing our health professionals?

(circle- 1 being not at all, 5 being very): 1 2 3 4 5

Do you have any history of anxiety (including anxiety attacks/panic attacks)? ____Yes ____ No

Are you taking any medications for anxiety/depression? If yes, please *specify*:_____

Office Policy

Office policy is that your portion of the services are paid for at each visit as they are performed. Claims to insurance not paid will be billed to the patient. In certain circumstances special arrangements for payment may be made by consulting the doctor and / or the office manager. We will prepare necessary reports to help collect your benefits from insurance companies, however, each fee is individual with the patient and not based on the assumption that the insurance company will pay all our charges.

Cancellation/ No Show / Late Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. If an appointment is canceled within **24 hours before your scheduled time**, you will be **charged a fifty dollar ($50) fee**; your insurance company will not cover this

Treatment Consent

This is to certify that I, undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and will assume responsibility for fees associated with those procedures.

Patient's (parent / guardian) Signature:_____ **Date:**_____

CDA Net

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient, parent or guardian: _____ **Date:**_____

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Balleza Inc. and authorize payment directly to her/him. This authorization shall continue in effect until the undersigned revokes the same.

Signature of subscriber: _____ **Date:** _____