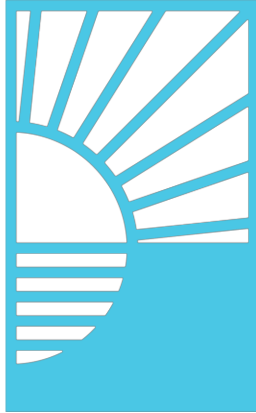

Sunrise
CENTRE DENTAL

Drs. John & Sharon Koncan

Please take a moment to review our office policies. We are happy to support you with any questions or concerns you may have.

FINANCIAL POLICY

Payment is required in full on the day of service. Methods of payment include cash, Visa, MasterCard, and Debit. We do direct bill your insurance company, but we do NOT accept assignment of benefits. Benefits will be payable to you, the subscriber. Your insurance assistance has been negotiated for you by your employer and all questions pertaining to your coverage should be directed to your employer or to your insurance company.

CANCELLATION POLICY

Your appointment is a time reserved especially for you. It is your responsibility to record this reserved time for future reference. As a courtesy, we will remind you of appointments by phone, text or email as the date approaches. We require 48 hours notice, during business hours, to change or cancel an appointment. Late notice or missed appointments will be subject to a minimum $100 charge. If there is a short notice cancellation or you fail to show for your appointment, we will require prepayment of your next visit to ensure our commitment to the time you have reserved.

Please Sign __________________________Date____________

MEDIC ALERT

PERSONAL INFORMATION

DATE ____________________

NAME______________________________, ______________________________, ____________
Last First Initial

SPOUSE ______________________ PARENTS/GUARDIANS (for minors) ______________________

ADDRESS______________________________ EMAIL______________________

CITY______________________ PROVINCE______________________ POSTAL CODE ____________

PHONE: Home ______________ Work ______________ Cell ______________ DATE OF BIRTH ____________

EMPLOYER ______________________ OCCUPATION ______________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________

PERSON RESPONSIBLE FOR PAYMENT: SELF SPOUSE PARENT OTHER: ______________

DENTAL ASSISTANCE NO YES INSURANCE CARRIER ______________________

PHYSICIAN ______________________ PHONE ______________

IN CASE OF EMERGENCY, PLEASE NOTIFY: Name______________________ Relationship______________

Phone # of Emergency Contact:______________________ DL# ______________

MEDICAL HISTORY

The following information is required by the dentist to assist in proper diagnosis and treatment. All information is confidential.

a. Are you presently under the care of a physician for medical treatment? NO YES
If yes, explain: ______________________

b. Have you been hospitalized in the last two years? NO YES
Specify: ______________________

c. Do you have a heart murmur or heart disease? NO YES
Specify: ______________________

d. Have you had any joint replacements, organ transplants or medical implants? NO YES
Specify: ______________________

e. Have you ever used any Tobacco products, Cannabis products or Vaping products? NO YES
If YES, please circle which one(s) and specify: ______________________
For how long?______________ How much/often do you smoke? ______________
If you have quit, how long ago? ______________

f. Have you ever had a reaction to any kind of medication? NO YES
Allergies - Specify:______________________

g. Are you presently taking any kind of medications? NO YES
A) Drug ______________ Reason ______________
B) Drug ______________ Reason ______________
C) Drug ______________ Reason ______________
D) Drug ______________ Reason ______________

h. Do you or have you had trouble stopping bleeding? NO YES

i. Have you ever had any injury or surgery to your face or jaws? NO YES
Specify:______________________

j. Do you have frequent/ severe headaches, earaches, or ear/throat infections? NO YES

k. Do you have hearing difficulties? ______________________ NO YES

l. Do you presently have or have you ever had:

Anemia	NO	YES	Diabetes	NO	YES	HIV Positive Test Result	NO	YES
Arthritis	NO	YES	Emphysema	NO	YES	Kidney Disease	NO	YES
Asthma	NO	YES	Epilepsy/Seizures	NO	YES	Measles/Mumps	NO	YES
Auto Immune Disorders	NO	YES	Glaucoma	NO	YES	Mental/Nervous Disorders	NO	YES
Blood Disorders	NO	YES	Hay Fever	NO	YES	Scarlet/Rheumatic Fever	NO	YES
Cancer	NO	YES	Heart Attack	NO	YES	Stroke	NO	YES
Chicken Pox/Shingles	NO	YES	Hepatitis A, B, or C	NO	YES	Tuberculosis	NO	YES

High/Low Blood Press NO YES ______________________________

m. Have you had radiation treatment or chemotherapy? NO YES

Specify: ______________________________

n. Have you ever taken cortisone or steroids? NO YES

Specify: ______________________________

o. Do you have any physical or mental limitations? NO YES

Specify: ______________________________

p. Have you ever had any illness/condition not mentioned above? NO YES

Specify: ______________________________

WOMEN ONLY

Are you pregnant? If so, what month are you in? ____________________ NO YES

Are you taking birth control pills? NO YES

DENTAL HISTORY

1. When was your last dental visit? ______________________________
2. How often do you brush your teeth? ____________________ Floss? ____________
3. Have you ever had a local anaesthetic? NO YES
4. Any complications? NO YES Specify: ____________________
5. Are any of your teeth sensitive to: NO
   Cold Sweets Heat Other ______________________________
6. Do your gums bleed when you: Brush Floss Spontaneously
7. Do you have any swelling or sore spots in your mouth? NO YES Specify: ____________
8. Do you feel you have bad breath? NO YES
9. Are you satisfied with the appearance of your teeth? NO YES
   What would you like to see changed? ______________________________

PATIENT CERTIFICATION, APPROVAL AND CONSENT

I certify that the medical information is correct, and I consent to my physician being contacted if necessary, as this information may be required for my dental care. I understand that treatment recommendations will be discussed with me following the examination. I will assume responsibility for fees associated with these procedures.

Patient Signature ______________________________ Date ____________

Parent/Guardian Signature ______________________________ Date ____________