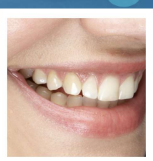
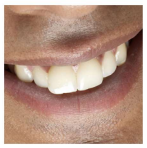
Anchor Health Services Anchor Dental Group
276 2nd Ave N.E. , Suite 3
Swift Current, SK S9H2C8

(306)778-9100
anchordental@sasktel.net
www.anchordentalgroup.com





Welcome to Anchor Dental Group

Patient Name:* [Last] * [First] [MI] [Preferred Name]

Health Card # ;

*

Date of Birth

*

If child, please list the name of the Guardian;

Please list any family members who are patients of our office.

Who or where did you hear about our office?

*

In an emergency who should be notified? Please enter Name and Phone number below:

*

Do you have Dental Insurance?

* ◯ Yes ◯ No

If insurance is applicable please hand insurance card(s) to reception so we may help you send claims in.

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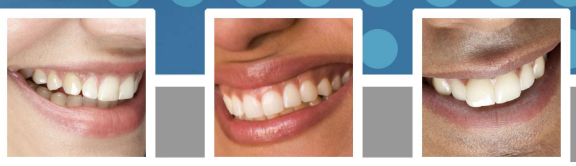

Financial Information

Person responsible for account:
Please complete all information if different than above.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) ____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____
_____ (City) ____ (PV) _____ (Postal Code)

Driver's Lic. #
_____

Employed by:
_____

Preferred method of payment;

☐ Cash ☐ Cheque ☐ Credit Card ☐ Debit

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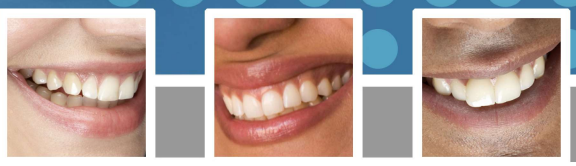

Dental Information

How would you rate the condition of your mouth?

◯ Poor ◯ Fair ◯ Good ◯ Excellent

I routinely see my dentist every:

◯ 3 mo ◯ 4 mo ◯ 6 mo ◯ 12 mo ◯ Not routinely

Previous Dentist Name and Phone Number:

Date of most recent dental exam, x-rays or visit:

What is your immediate dental concern?

*

Is there anything about the appearance of your smile that you would like to change?

Are you interested in any of the following:

☐ Teeth whitening or bleaching ☐ Cosmetic dentistry ☐ Orthodontic treatment
☐ Replacing missing teeth

Have you ever had any of the following treatment done?

☐ Periodontal Treatment ☐ Orthodontic Treatment
☐ A night guard or other appliance ☐ Root Canal Treatment
☐ Crowns or Bridges ☐ Dentures or Partial Dentures
☐ Dental Implants ☐ Extractions

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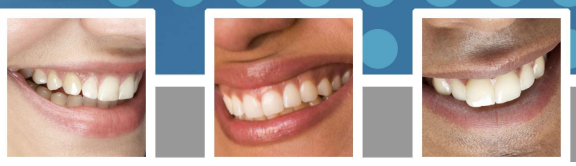

Have you ever experienced any of the following jaw problems:

- [ ] Popping / clicking in your jaw joints
- [ ] Difficulty in opening and closing
- [ ] Pain when teeth are clenched
- [ ] Pain or difficulty while chewing
- [ ] Pain in your jaw joints, around your ear, or side of your face
- [ ] Your jaw gets locked either open or closed
- [ ] Experience 'migraine' or 'tension' headaches
- [ ] Experience headaches in the right or left temple areas

Have you experienced any of the following?

- [ ] Growths or sore spots in mouth
- [ ] Your gums bleed when brushing or eating
- [ ] Suffer from pain or swelling of your gums
- [ ] Noticed any loose or shifting teeth
- [ ] Food catching between teeth
- [ ] Sensitivity to hot, cold, or sweets
- [ ] Clenching or grinding your teeth
- [ ] Biting your cheeks or lips
- [ ] Mouth breathing while awake or asleep
- [ ] Experienced proglonged bleeding after any procedures
- [ ] Concerns about halitosis (bad breath

How would you describe you gag reflex?

○ none ○ slight ○ moderate ○ severe

Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment or do you have any questions or concerns?

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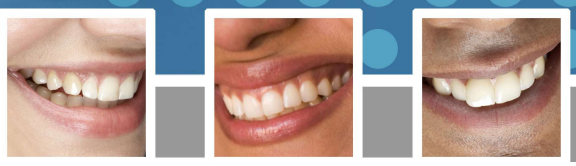

Consent for Services and Financial Policy

Appointments

Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore, at least 48 BUSINESS HOURS NOTICE MUST be given if cancellations are absolutely neccesary

Payment of fees

1. Office policy is that services are paid for at each visit as they are performed. However, in certain circumstances arrangements for payment may be made by consulting the office manager.

2. Regarding insurance: All professional services are CHARGED DIRECTLY TO THE PATIENT AND PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS ON THEIR ACCOUNTS. We will prepare any neccesary forms or reports to help collect your benefits from insurance companies.

General Release

I, the undersigned, certify that I have provided an accurate and complete personal and dental history and have not knowingly omitted any information.

Consent

I, the undersigned, hereby authorize the dentist and/or staff members to collect, use, and store x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs. I authorize the doctor to perform any and all forms of treatment, medication, and therapy/ that may be indicated and consent to the use of local anesthetic agents. I understand the above statements regarding the payment of fees and accept the responsibility for payment for Dental Services provided for myself or my dependant's, due and payable when services are rendered unless other financial arrangments have been made prior.

I also consent to the collection, use, retention and disclosure of personal information as is required for my own and my dependants dental care.

* ☐ By checking this box, I acknowledge that I have read this statement and agree to the contents.

Signature of patient, parent, or guardian & witness:

If not self please state name and relationship:

Response Date: