My Family Dentist

Dental Care for the Whole Family

Your teeth were meant to last a lifetime, we can help them go the distance.

myfamilydentist@shaw.ca
www.myfamilydentist.ca
420-233 Kennedy St.
Winnipeg, Manitoba
R3C 3J5
(204) 943-7271

NEW PATIENT HEALTH HISTORY FORM

Please spend a few minutes completing this New Patient Health History Form. Once complete, click on the print and submit to Dr. Raed Kamal Dental Corporation. If you wish to keep a copy for yourself, print an extra copy or simply click on File and Save As.

Title: | **Given Name**: | Preferred Name:

Surname: | **E-mail Address:**

Address: | Employer/School:

Province: | **Postal Code:** | **Date of Birth: (mm/dd/yy)** | **Gender:**

City: | Home #: | Preferred Contact Method:

Other Phone : | Work #: | Emerg. Contact: | Phone:

Are you available for Short Notice Appointments? | Emerg. Relation:

How did you hear about this office? | Drivers License Number or SIN:

DENTAL INFORMATION

In the following sections, please select whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during you initial visit you may be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Do your gums bleed while brushing or flossing?	◯ Yes	◯ No	Do you bite your lips or cheeks frequently?	◯ Yes	◯ No
Have you ever had Orthodontic (braces) Treatment?	◯ Yes	◯ No	Do you have Headaches or Migraine	◯ Yes	◯ No
Are your teeth sensitive to cold, hot, sweets or pressure?	◯ Yes	◯ No	Have you had any difficult extractions in the past?	◯ Yes	◯ No
Do you feel pain with any of your teeth?	◯ Yes	◯ No	Ever worn a night guard or other appliance?	◯ Yes	◯ No
Do you have any sores or lumps in or near your mouth?	◯ Yes	◯ No	Have you ever had difficulty opening or closing jaw?	◯ Yes	◯ No
Have you ever had a head, neck or jaw injury?	◯ Yes	◯ No	Have you had any pain in your jaw area?	◯ Yes	◯ No
Do you have any loose teeth or have they ever shifted?	◯ Yes	◯ No	Have you ever had Periodontal Treatment (gums)?	◯ Yes	◯ No
Does food frequently get caught in your teeth?	◯ Yes	◯ No			

If you have a current dental problem, please describe:

Please give a brief description of your Oral Hygiene habits:

Do you have any other concerns about having Dental Treatment? If so, please explain. ◯ Yes ◯ No

Please enter your previous Dentist name and Location:

Are you happy with the appearance of your teeth? If no, please explain. ◯ Yes ◯ No

Do you ever feel nervous about visiting the Dentist? If so, please explain. ◯ Yes ◯ No

Date of your last Dental X-Ray: | Date of your last teeth cleaning: | Date of your Last Dental Exam:

Have you ever been advised to take antibiotics prior to dental treatment? ◯ Yes ◯ No

What can we do to make you smile? Check all that apply, and we'll get back to you with more information about your inquiry:

☐ Veneers	☐ Invisalign Invisible Braces	☐ Custom Teeth Whitening	☐ Instant Orthodontics	☐ Broken/Cracked Teeth
☐ Gummy Smile	☐ Total Smile Makeovers	☐ Replace Missing Teeth	☐ Cosmetic Dentures	☐ Dental Implants
☐ White Fillings	☐ Rejuvenate Worn/Stained Teeth	☐ Correct Misaligned Teeth	☐ Cavity Prevention	☐ Eliminate Gaps

MEDICAL INFORMATION

Dental professionals primarily treat the area in and around your mouth, but since your mouth is part of your body, any medication you are taking and your health History have a important relationship with your Dental Treatment. Please answer the following question.

Are you currently seeing a Family Physician? If so, please enter name, phone number, and address. ◯ Yes ◯ No

Have you recently (in the last two years) been hospitalized or had a major operation? Please explain. ◯ Yes ◯ No

Have you ever had a serious head or neck injuy? If so, please explain. ◯ Yes ◯ No

Date of your last Physical Exam:

Are you pregnant? ◯ Yes ◯ No If yes, what is the expected delivery date? Are you taking birth control medication? ◯ Yes ◯ No

Please go over the following section and indicate which of the following you have or have had. If you need to add any further information, please enter it at the end.

AIDS/HIV Positive	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Circulation Problems	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy/Seizures	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Fainting	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Head or Neck injuries	◯ Yes ◯ No	Mental/Nervous Disorder	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Organ/Medical Transplant	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Heart Pace Maker	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Heart Surgery	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No

Please enter details or any further information.

Please list any prescription or non-prescription medicine you are currently taking or have recently taken:

Are you allergic to or have you had a reaction to any of the following items?

Barbiturates, sedatives or sleeping pills	◯ Yes ◯ No
Antibiotics	◯ Yes ◯ No
Aspirin	◯ Yes ◯ No
Codeine	◯ Yes ◯ No
Ibuprofen	◯ Yes ◯ No
Acetaminophen	◯ Yes ◯ No
Local Anaesthetic	◯ Yes ◯ No

Other:

Do you use any form of Tobacco or are wearing a nicotine patch? ◯ Yes ◯ No

Are you dependent on Alcohol or drugs? ◯ Yes ◯ No

If so, have you received treatment? ◯ Yes ◯ No

Have you ever tested HIV positive? ◯ Yes ◯ No

If you have ever been advised against taking any type of medication, please list them below.

If you have any allergic conditions please list them below. This can include asthma, hay fever, food allergies, and metal or latex allergies.

Do you bruise easily, or bleed severely when you are cut? ◯ Yes ◯ No

Do you have severe earaches; ear, throat or sinus infections; or headaches? ◯ Yes ◯ No

Do you wear eyeglasses or contact lenses? ◯ Yes ◯ No

Children Only

Please list any medical conditions or illnesses the child has recently had. This can include Measles, Strep Throat, Tonsillitis.

PAYMENT POLICY

This policy will be updated from time to time. Please enquire with office staff for any changes to the Payment Policy.

As you are surely aware, the vast majority of dental services are not covered by Manitoba Health. This means the fees we charge are the sole responsibility of the patient. With this in mind we will do our best to ensure you are aware of the fees for your non-routine treatment prior to initiating such treatment. If you have questions about your routine treatment fees, (eg. cleanings), feel free to ask. In cases where planned treatment exceeds $300.00, or it is questionable whether your insurance benefits will cover the procedure, (eg. crowns), treatment plans with full estimates will usually be provided. Upon patient request, written estimates will be supplied for work under the $300.00 amount.

In many cases our office follows the current Manitoba Dental Association Fee Guide for the fees listed in the guide. Some of our fees may differ from the fee guide as the guide lists average fees and do not always apply due to complexity of treatment or materials being used. There are some fees we charge from the Canadian Dental Association master guide which are not found in the Manitoba Dental Association Fee Guide. These codes are not always recognized by provincial dental plans.

For patients with dental benefits we will submit claims on your behalf and accept assignment of the benefits, where permitted by the benefits plan (some exceptions apply). We will work with you to help you determine what your benefit coverage is, but as each benefit plan is different, even for plans offered by the same company, it is up to our patients to know what their coverage is.

As advancements in dentistry take place, new codes (fees) are added to the fee guide to reflect these changes. However, not all dental plans are up-to-date with providing coverage for these codes, or for providing coverage on the current year's fee guide.

For codes that we routinely have the most trouble with we will often send in a predetermination to your benefits provider to assess the coverageprior to treatment. Please note that these codes often are associated with lab fees and when these predeterminations are returned, the lab fees are often excluded from the benefit provider's calculations.

It is important to note that your dental benefits package is usually provided by your employer. If you have any concerns about the quality of your benefits package, please talk to your employer. When it comes to the utilization of the benefits package you have, we will assist you any way we can.

Our office accepts Master Card, Visa, cheques ($30 NSF charges on all returned cheques), debit, and cash. Please note we do not accept or provide change when paying with cash. Excess payments will be maintained as a credit on your account and applied to future billings.

Please note, rescheduling appointments with less than a full business day's notice, and missed appointments are subject to a short-cancel/no-show fee of $65.00, which is not covered by insurance.

Please note, photos and x-rays taken at Kamal Dental are the property of Dr. Raed Kamal Dental Corporation and may be used for marketing and or educational purposes (patient identification will be removed). Copies are available upon request. A fee for reproduction may be charged for this service.

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

INSURANCE INFORMATION

Primary Insurance

Subscriber Name: Relationship:

Insurance Name:

Policy Number: Policy Description:

Subscriber ID #: Division Number:

Secondary Insurance

Subscriber Name: Relationship:

Insurance Name:

Policy Number: Policy Description:

Subscriber ID #: Division Number:

Authorized Consent to Release Information

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of and services described to Dr. Raed Kamal Dental Corporation and its representatives. This includes but is not limited to the submission of x-rays for claim processing and gathering of insurance benefit details.

This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient, parent, or guardian:

Authorized Consent to Release Information

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Raed Kamal Dental Corporation and its representatives and authorize payment directly to it and its representatives.

This Authorization shall continue in effect until the undersigned revokes the same.

Signature of patient, parent, or guardian:

Note: signatures on this form provide consent for insurance information listed here, as well as insurance information currently on file with Dr. Raed Kamal Dental Corporation as updates to insurance information may occur and will not be updated here.

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Please note, submission by e-mail is not secure and will transfer your personal information.