The Smile Dentist

PATIENT INFORMATION FORM

DR. BRUNO PALIANI

COSMETIC AND GENERAL DENTISTRY FOR TEENAGERS AND ADULTS

SMILE ENHANCEMENTS AND EXTREME SMILE MAKEOVERS

SMILE SERVICES

PORCELAIN VENEERS
PORCELAIN CROWNS
INVISALIGN™
ANGELLIFT™
PEAK™ TEETH WHITENING
ESTHETIC BRIDGES
TOOTH-COLOURED INLAYS/ONLAYS
ONE-APPOINTMENT BONDING
TOOTH-COLOURED FILLINGS
ESTHETIC DENTURES
ESTHETIC IMPLANTS

Date: ___________ / ____ / ________
Month / DD / YYYY

Reason: [ ] Consultation [ ] Examination [ ] Teeth Whitening

[ ] Yellow, Discoloured, Stained Teeth
[ ] Crooked, Crowded Teeth, Teeth Sticking Out or In
[ ] Gaps and/or Spaces between Teeth, Missing Teeth
[ ] Chipped/Cracked/Worn Down Teeth
[ ] Big/Small Teeth, Long/Short Teeth, Funny Shaped Teeth
[ ] Broken Fillings, Broken Teeth
[ ] Old, Dark, Discoloured Fillings
[ ] Gummy Smile (excessive gum shows when smiling)
[ ] Teeth Sensitive to Hot/Cold
[ ] Loose Tooth/Teeth
[ ] Chewing or Biting Difficulties/Pain
[ ] Clenching/Grinding (now or in the past)
[ ] Pain, Discomfort, Infection, Swelling
[ ] Bleeding/Sore Gums (red, inflamed)
[ ] Unhappy with General Appearance of Teeth/Smile
[ ] Smile with lips together/Hand in front of Mouth
[ ] Disappointed with your teeth/smile when viewing photos
[ ] Decreased Self-Confidence (Smile-Related)
[ ] I have the following appliances: (please circle)
Dentures, BitePlane, Retainers, Bleaching Trays, Other

Name: ______ ________________ ________ ____________________________
(title) **(first)** **(middle initial)** **(last)**

Address: ______ ____ _______
(#) **(street name)** **(unit/apt. #)**

____________________________ ___________ ______________
(city) **(province/state)** **(postal/zip code)**

Birth Date: ___________ / ____ / ________
Month / DD / YYYY **[ ] Male [ ] Female Marital Status:** _______________

Home Phone # : (_____)______________________ **[ ] Preferred Contact Number**

Work Phone #: (_____)______________x_______ **[ ] Preferred Contact Number**

Cellular Phone #: (_____)______________________ **[ ] Preferred Contact Number**

E-mail:____

Date of Last Dental Visit:______________________
What was done?____

1. Any Medical Conditions?____
2. Taking any Medications?____
3. Any allergies (meds/other)?____
4. Have heart murmur/rheumatic fever?_____________________________________
5. Have you ever had a heart attack? If yes, when?_________________________
6. Have you ever had a joint replacement?_________________________________
7. Treated by a specialist/MD now?____
8. Do you have any current x-rays? [ ] Bitewings [ ] Panoramic [ ] Full Mouth Series
9. Do you have dental benefits? [ ] Yes [ ] No

Who may we thank for referring you to our office? _______________________________

<u>OR</u> How did you hear about Dr. Paliani and our Smile Services? _____________________

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***** We ask that all new patients joining our practice familiarize themselves with our "Treatment Payment Options and Financial Policy" (SEE OVER) *****

Beautiful Healthy Smiles

Treatment Payment Options and Financial Policy

Dental treatment is an excellent investment in your medical and psychological well being and financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following payment options for our patients.

AFFORDABLE PAYMENT OPTIONS

FINANCIAL POLICY

Payment of the **professional fees is required in advance of treatment.**

For major work consisting of a bonding appointment, **the lab fee must be paid for in full prior to the bonding appointment**. The lab fees charged are exactly the same fees as invoiced by the dental lab. A copy of the lab bill is available upon request.

In-House Payment Options:

5% good patient courtesy discount applies to charges **over $500** for payment **in advance** by:

- ❑ **Cash & Debit Card (for fees less than $1000.00)**
- ❑ **Money Order, Bank Draft or Certified Cheque**
- ❑ **Bank Transfer***

  ***Bank Transfer to: Paliani Dentistry Professional Corporation**
  Bank of Montreal (001) Transit: 3693 Acct: 1998-555

2.5% good patient courtesy discount applies to charges **over $500** for payment **in advance** by:

- ❑ **Major Credit Cards: Visa, MasterCard, and American Express**

Financing Options:

DentalCard (*ONLINE APPLICATION -* www.DentalCard.ca – 1-888-689-9876)

- No down payment, no annual fees & no pre-payment penalties
- Flexible payment terms ranging from 6 to 60 months
- INTEREST FREE for 3, 6 or 12 months (for amounts >$1000)
- Competitive interest rates from 9.95%
- Quick and easy application process (online, fax or telephone)
- Equal monthly payments will be debited from your bank account
- See brochures for more detailed information and application form

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I understand that fees for certain procedures are at the current suggested ODA Fee Guide, but many are above the current ODA Fee Guide. I also understand that fees could be below, the same or higher than other general dentists/dental specialists/denturists in the area.

I have familiarized myself with this financial policy and understand that all fees are due, in full, in advance or at the time of the appointment, regardless of any insurance involvement.

Dated at London, Ontario, this ____________ day of ____, 20______

PRINTED: ____
Name of Patient

SIGNED: ____
Signature of Patient

SIGNED: ____
Parent, Guardian or Nearest Kin
if patient is under the age of 18