

## PATIENT INFORMATION FORM

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month / DD / YYYY

### 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

Reason:  Consultation  Examination  Teeth Whitening

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

- Any Medical Conditions? \_\_\_\_\_
- Taking any Medications? \_\_\_\_\_
- Any allergies (meds/other)? \_\_\_\_\_
- Have heart murmur/rheumatic fever? \_\_\_\_\_
- Have you ever had a heart attack? If yes, when? \_\_\_\_\_
- Have you ever had a joint replacement? \_\_\_\_\_
- Treated by a specialist/MD now? \_\_\_\_\_
- Do you have any current x-rays?  Bitewings  Panoramic  Full Mouth Series
- Do you have dental benefits?  Yes  No

Who may we thank for referring you to our office? \_\_\_\_\_

**OR** How did you hear about Dr. Paliani and our Smile Services? \_\_\_\_\_

\*\*\* 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: 36932 Acct: 1005-752

**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](http://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