DENTAL HEALTH GROUP

CHILDREN'S NEW PATIENT FORM

PERSONAL INFORMATION:

O MALE O FEMALE

NAME: _____ PREFERRED NAME: _____
LAST FIRST MIDDLE

DOB: _____ NAME OF GUARDIANS: _____

ADDRESS: _____ APT/UNIT#: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ PARENTS CELL: _____ PARENTS WORK: _____

EMAIL: _____

*In an effort to save paper, most of our patients enjoy the convenience of email and text message reminders.
Your personal information is never shared with a third party and you can opt out of these green initiatives at any time

NAME OF SCHOOL: _____ GRADE: _____

ANY HOBBIES, SPECIAL INTERESTS OR PETS?: _____

HOW DID YOU HEAR ABOUT US? – PLEASE SELECT ONE OF THE FOLLOWING:

O Location/Sign O Google O Yellow Pages O Person: _____

O Website O Facebook O Billboard O Previous Patient O Other: _____

PRIMARY BENEFIT INFORMATION:

POLICY HOLDER: _____ DOB: _____
NAME AS IT APPEARS ON BENEFIT CARD

EMPLOYER: _____ DENTAL INSURANCE COMPANY: _____

POLICY #: _____ CERTIFICATE #: _____

SECONDARY BENEFIT INFORMATION:

POLICY HOLDER: _____ DOB: _____
NAME AS IT APPEARS ON BENEFIT CARD

EMPLOYER: _____ DENTAL INSURANCE COMPANY: _____

POLICY #: _____ CERTIFICATE #: _____

DENTAL HISTORY:

REASON FOR TODAY'S VISIT:

O ROUTINE CHECK UP	O APPEARANCE OF TEETH	O ACCIDENT OF TEETH: _____
O NEW EXAMINATION	O FACE SWELLING	O BLEEDING AROUND TEETH
O TOOTHACHE: _____	O CROWDING OF TEETH	O OTHER: _____

HAS THERE BEEN A PREVIOUS DENTIST: O YES O NO – *IF YES, O FAMILY DENTIST* ***OR*** *O SPECIALIST*

ANY UNFAVOURABLE EXPERIENCE IN A DENTAL OFFICE: O YES O NO – *IF YES, PLEASE EXPLAIN:* _____

DENTAL HISTORY CONTINUED – IS THERE A HISTORY OF ANY OF THE FOLLOWING:

IS THERE ANY ORAL HABITS: O LIP SUCKING/BITING | O THUMB OR FINGER SUCKING | O NAIL BITING

HAS THERE BEEN A PREVIOUS FACIAL OR DENTAL INJURY: O YES O NO – IF YES, PLEASE EXPLAIN: _____

AT WHAT AGE DID THE ACCIDENT TAKE PLACE: _____ WHAT TEETH WERE INVOLVED: _____

MEDICAL HISTORY

IS YOUR CHILD PRESENTLY UNDER OBSERVATION OR TREATMENT FOR ANY CONDITION?: O YES O NO
IF YES, PLEASE EXPLAIN: _____

HAS YOUR CHILD EVER HAD SURGERY? O YES O NO – *IF YES, PLEASE EXPLAIN:* _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? O YES O NO *–IF YES, PLEASE EXPLAIN:* _____

HAS YOUR CHILD EVER HAD GENERAL OR LOCAL ANAESTHETIC? O YES O NO

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

YES	NO		YES	NO		YES	NO	
O	O	ASTHMA	O	O	MENTAL DISORDER	O	O	HEPATITIS/LIVER DISORDER
O	O	CANCER: _____	O	O	EPILEPSY OR SEIZURES	O	O	RHEUMATIC FEVER
O	O	CONGENITAL DEFECTS	O	O	HEART MURMUR	O	O	SICKLE CELL ANEMIA
O	O	DIABETES	O	O	HEART PROBLEMS	O	O	THALASSEMIA
O	O	EASY BLEEDING BRUISING	O	O	HEART SURGERY	O	O	OTHER: _____
O	O	EATING DISORDERS	O	O	HEMOPHILIA	O	O	OTHER: _____

PLEASE LIST ANY ALLERGIES OR SENSITIVITIES (INCLUDING BUT NOT LIMITED TO FOOD, LATEX, METALS, ANESTHETICS, ANTIBIOTICS):

_____ _____ _____ _____

_____ _____ _____ _____

PLEASE LIST ANY MEDICATIONS, DOSAGES AND CONDITION TAKEN FOR (INCLUDE SUPPLEMENTS AND COLD REMEDIES)

_____ _____

_____ _____

_____ _____

ANYTHING ELSE ABOUT YOUR CHILD'S HEALTH THAT WE SHOULD KNOW:

_____

_____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history for my child and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my child's medical – dental history. Should there be any change in my child's health status in the future, I will advise this dental office.

I authorize the dentist to perform diagnostic procedures upon my child as may be required to determine necessary treatment. I understand that information provided from or to my child's medical doctor or another health care provider may be necessary, and I consent to the release of this information. I understand that responsibility for payment of the dental services for my dependents is mine regardless of any dental benefits, and I assume full responsibility for fees associated with these services.

_____

Signature – GUARDIAN Print name of GUARDIAN DATE

DENTAL HEALTH GROUP

PATIENT CONSENT FORM
GENERAL RELEASE FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly.

In this office, Lorrie Richards (Business Manager) acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information. Attached to this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention, and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENT'S PERSONAL INFORMATION

This office will collect, use and disclose information about you for the following purposes:

- to deliver safe and efficient patient care
- to assess your health needs
- to advise you of your treatment options
- to establish and maintain communication with you
- to communicate with other treating health-care providers, including specialist and general dentist who are the referring dentist and/or peripheral dentist
- EDI- to allow us to submit dental claims electronically (paperless claims processing), as well as electronic funds transfer and electronic inquiry for claim status and patient eligibility
- for teaching and demonstrating purposes on an anonymous basis
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the *Regulated Health Professions Act*
- to deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to permit potential purchasers, practice brokers or advisors to evaluate the dental practice
- to process credit card payments
- to assist this office to comply with all regulatory requirements
- to identify and to ensure continuous high quality service
- to provide health care
- to enable us to contact you
- to allow us to efficiently follow-up for treatment, care and billing
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- to complete and submit dental claims for third party adjudication and payment
- to comply with agreements/undertakings entered into voluntarily by the member with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to collect unpaid accounts

By signing this form, you have agreed that you have given your informed consent to the collections, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue. Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review and permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

By signing this form, you are also acknowledging that you are aware that some Dental Health Group's fees and procedures are different then the voluntary Dental Association fee guide. This difference is based on a number of reasons including the increasing cost of technology, supplies, materials and the cost of delivering services. If you require more information on this fee structure, please do not hesitate to ask. Patients should also be aware that Dental Health Group is not connected to nor are we participating member of any dental insurance plans and we charge fees based on the level of work required and performed, not the level of benefit coverage.

It is important for you to know that your dental insurance policy is an agreement between you (the patient), your employer (if applicable), and your dental insurance carrier. We suggest to our patient that they familiarize themselves with their individual insurance policies as we are not responsible for being aware of the benefits and limitations provided within each plan. As a courtesy we will be happy to file your dental claims but the follow up with pending claims is the patients' responsibility.

I have reviewed the above information that explains how your office will use my personal information, and office policies. I know that your office has a Privacy Code, and I can ask to see the Code at any time. I agree that Dental Health Group and its successor can collect, use and disclose personal information about _____ (Patient's Dependent's Name), as set out above in the information about the office's privacy policies.

_____

Signature | Date | Witness