DENTAL HEALTH GROUP

NEW PATIENT FORM

PERSONAL INFORMATION:

O Mr. O Mrs. O Ms. O Miss O Dr. O MALE O FEMALE

NAME: ____ DOB: ________________
LAST FIRST MIDDLE

PREFERRED NAME: ____________________ NAME OF GUARDIAN (IF APPLICABLE): ____________________

ADDRESS: ____ APT/UNIT#: ____________

CITY:____________________ PROVINCE: ____________________ POSTAL CODE: ____________________

HOME PHONE: ____________________ CELL PHONE:____________________ WORK PHONE: ____________ EX.______

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

IN CASE OF AN EMERGENCY – PLEASE CONTACT: ____________________ PHONE NUMBER: ____________________

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 EXAMINATION O EMERGENCY: ________________ O OTHER: ____________________

IS THERE A DENTAL PROBLEM YOU'D LIKE TREATED IMMEDIATLEY?: ______________________________

DATE OF LAST DENTAL VISIT? ______________ LAST CLEANING? ________________ LAST X-RAYS? ______________

DO YOU HAVE ANXIETY WITH DENTAL TREATMENT: ______________________________

HOW OFTEN DO YOU BRUSH YOUR TEETH: ______________ HOW OFTEN DO YOU FLOSS YOUR TEETH: ______________

DENTAL HISTORY CONTINUED – DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

YES	NO		YES	NO		YES	NO	
O	O	ORTHODONTICS	O	O	DENTURES	O	O	HEADACHES/MIGRAINES
O	O	ORAL/GUM SURGERY______________	O	O	CLENCHING	O	O	GRINDING
O	O	INJURY OR SURGERY TO FACE/JAW	O	O	BAD BREATH	O	O	ORAL SORES OR GROWTHS
O	O	JAW PAIN or CLICKING	O	O	BLEEDING GUMS	O	O	SENSITIVITY TO HOT OR COLD

HAVE YOU EVER BEEN ADVISED TO TAKE ANTIBIOTICS BEFORE A DENTAL APPOINTMENT: O YES O NO
IF YES, PLEASE EXPLAIN: ____

ARE YOU COMPLETELY HAPPY WITH THE SHAPE, COLOUR AND POSITION OF YOUR TEETH: O YES O NO
IF NO, PLEASE EXPLAIN: ____

ON A SCALE OF 1 TO 10 (10 BEING THE HIGHEST), PLEASE RATE HOW IMPORTANT YOUR ORAL HEALTH IS TO YOU: __________

MEDICAL HISTORY

DO YOU HAVE A PRIMARY PHYSICIAN? O YES O NO – NAME: ___________________________ LAST EXAM DATE: __________

WERE ANY PROBLEMS IDENTIFIED? O YES O NO – *IF YES, PLEASE EXPLAIN:* ____

DO YOU SMOKE/CHEW TOBACCO or VAPE? O YES O NO – *IF YES, HOW MANY PER DAY?* ________________________________

ARE YOU PREGNANT OR SUSPECT YOU MAY BE? O YES O NO – *IF YES, WHEN IS YOUR DUE DATE?:* _________________________

DOES YOUR FAMILY HAVE A HISTORY OF CANCER, HEART DISEASE OR DIABETES? O YES O NO –*IF YES, WHAT TYPE:* ___________

HAVE YOU EXPERIENCED COMPLICATIONS FOLLOWING A MEDICAL OR DENTAL PROCEDURE? O YES O NO

DO YOU TAKE MEDICATION FOR OSTEOPOROSIS? O YES O NO –*IF YES, WHAT TYPE:* _____________________________________

HAVE YOU EVER HAD RADIATION TREATMENT TO THE HEAD OR NECK REGION: O YES O NO

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

YES	NO		YES	NO		YES	NO	
O	O	ANEMIA	O	O	EMPHYSEMA	O	O	KIDNEY DISEASE
O	O	ANGINA	O	O	EPILEPSY OR SEIZURES	O	O	LIVER DISEASE
O	O	ARTHRITIS	O	O	FAINTING/DIZZY SPELLS	O	O	LUNG DISEASE
O	O	ARTIFICIAL HEART VALVE	O	O	GASTROINTESTINAL DISORDERS	O	O	LUPUS/AUTOIMMUNE
O	O	ARTIFICIAL JOINTS **WHEN:** _______	O	O	GLAUCOMA	O	O	MENTAL DISORDER
O	O	ASTHMA	O	O	HEARING IMPAIRMENT	O	O	ORGAN TRANSPLANT
O	O	CANCER: ____________________	O	O	HEART ATTACK **WHEN:** _______	O	O	PACEMAKER
O	O	CHEMO/RADIATION THERAPY	O	O	HEART MURMUR	O	O	SCARLET FEVER
O	O	COPD	O	O	HEPATITIS A/B/C	O	O	STOMACH ULCER
O	O	DIABETES TYPEI / TYPEII	O	O	HERPES	O	O	STROKE
O	O	DRUG/ALCOHOL DEPENDENCY	O	O	HIGH/LOW BLOOD PRESSURE	O	O	THYROID DISEASE
O	O	EASY BLEEDING OR BRUISING	O	O	HIV+ / AIDS	O	O	TUBERCULOSIS
O	O	EATING DISORDERS	O	O	HYPERTENSION	O	O	VISION IMPAIRMENT
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) (YOU MAY ATTACH A SEPARATE SHEET)

____ ____
____ ____
____ ____

ANYTHING ELSE ABOUT YOUR HEALTH THAT WE SHOULD KNOW: ____

DENTAL HEALTH GROUP

PATIENT CONSENT FORM

GENERAL RELEASE FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

To the best of my knowledge, the above personal, dental and medical information is correct and complete; I have not omitted any information. Should there be any changes in either my health status or any other information I have provided, I will advise this dental office. This is to certify that I, the undersigned, consent to the performing of dental procedures agreed to by myself and the dentist. I also understand that information provided from or to my medical doctor or another health care provider may be necessary. I authorize the dentist to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis and ensure my safe and proper treatment. I also understand that the responsibility for the fees associated with any procedures or mine or my dependents is mine regardless of any insurance benefit I may have.

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, Jillian Gorbold (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