In an effort to serve you better, We would ask that you complete the following. We will be glad to assist you. **PLEASE PRINT**.

Chart#

Patient Information A parent or guardian will be responsible for decisions on my treatment. Yes ☐ No ☐

Full Name:____ Sex: M ☐ F ☐

Address: ______________________________City: _______ Prov._____ Postal Code:__________

Date of Birth: D / M / Y Home Tel. (________) __________ ***CELL #** (________) __________

***EMAIL ADDRESS:** ____

Emergency Contact: ______________________________Tel. (_________) ______________

Family Doctor: ______________________________Tel. (_________) ______________

Referring Doctor: ______________________________Tel. (_________) ______________

Financial Information: Method of Payment: Cash____ Cheque____ Credit Card____ Insurance____ Other____

Person responsible for financial matters: Self____ Spouse____ Parent/Guardian____ Other____

Name: ____

Address: ____

Date of Birth: D / M / Y Home Tel. (________) __________ Work Tel. (________) __________

Driver's License: ____________________ or S.I.N ____________________

Primary Insurance:

Insurance Company: ______________________________ Tel. (________) ______________

Employer/Policy holder: ______________________________ Insurance Yr. End:______________

Policy #: ______________________________ ID/S.I.N#: ______________

Max. Coverage:___________ Basic___________% Major Restorative___________% Orthodontic___________%

Secondary Insurance:

Insurance Company: ______________________________ Tel. (________) ______________

Employer/Policy holder: ______________________________ Insurance Yr. End:______________

Policy #: ______________________________ID/S.I.N#: ______________

Max. Coverage:___________ Basic___________% Major Restorative___________% Orthodontic___________%

DENTAL HISTORY

1. What is the reason for today's visit? Emergency_____ Examination_____ Other______________________
2. How frequently do you see a dentist? 3-6 months_____ Annually_____ Other______________________
3. When was your last dental visit?____________________ Last X-ray?______________________
4. How often do you brush per day?_______________ Floss?_______________ Anti-Bacterial Rinse?_______________
5. Are your teeth sensitive to: Cold______ Sweets______ Heat______ Other______________________
6. Do your gums bleed when: Brushing_____ Flossing_____ Never_____
7. Do your gums feel swollen or tender? **YES** **NO**
8. Do you have bad breath or a bad taste in your mouth? **YES** **NO**
9. Do your jaws crack, pop, or grate when you open widely? **YES** **NO**
10. Do you grind or clench your teeth? **YES** **NO**
11. Does food catch between your teeth? **YES** **NO**

12. Have you ever had local anaesthesia (freezing) **YES** **NO**

13. Have you ever had any problems with previous dental treatments? **YES** **NO**

14. Have you ever had any of the following: Bridgework____ Crown/caps____ Full/Partial Dentures____
Orthodontic____ Periodontal (Gums)____ Root Canal____

15. Are you satisfied with your teeth? **YES** **NO** Specify____

MEDICAL HISTORY

1. Are you presently under the care of a physician? If so, explain_______________________________________ **YES** **NO**

2. Have you ever been hospitalized? **YES** **NO**

   Explain____

3. Are you taking any drugs or medication at this time? . . . .**YES** **NO**

   A. Drug___________________________________Reason________________________

   B. Drug___________________________________Reason________________________

   C. Drug___________________________________ Reason________________________

4. Have you ever had an adverse effect to any of the following: **Antibiotics- Penicillin___ Other___**

   Aspirin___ Barbiturates(sleeping pills)___ Codeine___ Darvon___ Local Anaesthesia___

5. Have you ever been warned against using any other medications?. . . . .**YES** **NO**

   Which?____

6. Have you ever taken prolonged medical or non-medical drugs?. . . . . **YES** **NO**

   Which?____

7. Do you suffer from any allergies (hay fever, latex, etc.) Which?____ **YES** **NO**

8. Do you bruise easily or have prolonged bleeding? . . . .**YES** **NO**

9. Do you smoke? How much per day?____________________ . . . . **YES** **NO**

10. Have you ever fainted, had shortness of breath or chest pains? . . . .**YES** **NO**

11. **WOMEN** Are you pregnant? **YES or NO** Using birth control? **YES or NO** Reached menopause? **YES or NO**

12. Do you have or have you had any of the following? Please check. NONE___

__A.I.D.S	__Cortisone/Steroid Treatment	__H.I.V. Positive	__Radiation/Chemotherapy
__Anemia	__Diabetes	__Hodgkin's Disease	__Rheumatic/Scarlet Fever
__Angina	__Drug/Alcohol Dependence	__Hyper/Hypo Glycemia	__Sickle Cell Disease
__Anorexia Nervosa	__Emphysema	__Hypertension	__Sinus Trouble
__Artificial heart valve	__Epilepsy	__Jaundice	__Stomach/Intestinal Problems
__Arthritis/Rheumatism	__Glandular Disorders	__Kidney Disease	__Stroke
__Artificial Joints (hips, knees)	__Glaucoma	__Liver Disease	__Thyroid Disease
__Asthma	__Head/Neck Injuries	__Leukemia	__Tuberculosis
__Blood Disorders	__Heart Disease/Attack	__Lung Disease	__Ulcers
__Bronchitis	__Heart Murmur	__Malignant Hypothermia	__Venereal Disease
__Bulimia	__Heart Pacemaker/Surgery	__Mental/Nervous Disorder	__Other____________________
__Cancer	__Heart Rhythm Disorder	__Mitral Valve Prolapse	
__Circulation Problems	__Hepatitis A/B/C	__Organ Transplant/Implant	
__Congenital Heart Lesions	__Herpes	__Psychiatric Disorders	

13. **CHILDREN** Have you recently had any of the following (appropriate date)?

Chicken Pox_________________________ Measles_________________________ Mumps_________________________

Strep Throat________________________ Tonsillitis__________________________ NONE___

GENERAL RELEASE

I, the undersigned, understand that the information contained in the dental and medical history is important to my treatment. I certify that all of the information that I have completed is correct and that I have not knowingly omitted any data. I consent to the release of medical information from my medical doctor or other healthcare provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as my be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_______________________________________ _______________________________________ ____________________

Signature of Patient or Parent/Guardian Print Name Date

INFORMED CONSENT

GENERAL RELEASE

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist
- I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance company may pay less than the actual bill for services .l understand I am financially responsible for payments in full of all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.
- I authorize the setting up of my dental file, its follow-up, as well as my registration on the recall list(s) of the treating dentist(s).
- I have been informed that my file will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it.
- l attest to the accuracy of the information on this registration form.

____ _______________________

Signature of Patient or Parent/Guardian *Date*

MEDICAL/DENTAL INFORMED CONSENT

- I, the undersigned, certify that I have provided, to the best of my knowledge, an accurate and complete medical & dental history and have not knowingly omitted any information. I consent to my dentist obtaining from other practitioners who are currently treating me or have treated me, such further information as maybe necessary for providing me with proper dental treatment and care. I hereby promise to inform my dentist of any changes to my health status.

____ _______________________

Signature of Patient or Parent/Guardian *Date*

SIGNATURE ON FILE

- I authorize release to my insuring company(s) plan administrator(s) the information contained in claims submitted electronically.
- I hereby assign my benefits payable from claims submitted electronically to Dr.________________________ and authorize payment directly to him/her.

____ _______________________

Signature of Patient or Parent/Guardian *Date*

PATIENT CONSENT FORM

COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also tried to be as open and transparent as possible about the way we handle your personal information. It is important to provide this service to our patients.

In this office, Dr. Pravin Patel 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 you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Below is an outline of what our office is doing to ensure privacy protection:

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

Collection, Use and Disclosure of Patient's Personal Information

To help you understand the importance of keeping your information private, we have outlined below how our office is using and disclosing your information.

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

- To provide health care.
- To deliver safe and efficient patient care.
- To identify and to ensure continuous high quality service.
- To advise you of treatment options.
- To enable us to set up a file on you or your children.
- To enable us to contact you.
- To establish and maintain communication with you.
- To offer and provide treatment, care and services in relationship to the oral and maxillofacial dental care.
- To allow us to maintain communication and contact you to distribute healthcare information and to book and confirm appointments.
- To communicate with other treating healthcare providers, including specialists and general dentists who are referring dentists and/or peripheral dentists.
- To allow us to efficiently follow-up for treatment, care and billings either to you directly or indirectly.
- To complete and submit dental claims for third party adjudication and payment.
- To collect unpaid accounts.
- To process credit card payments.
- To invoice for goods and services and laboratory services.
- For consultations with a specialist for specific treatment modalities such as orthodontics.

- For teaching and demonstrating purposes on and 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 RHPA.
- 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 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 prepare materials for the Health Professions Appeal and Review Board.
- To assist this office to comply with all regulatory requirements and generally with the law.
- To permit potential purchasers, practice brokers or advisors to evaluate the dental practice.
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale.

By signing this consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal and/or children 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 **RHPA**, and for a defense of a legal issue.

Our office will not under any condition 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 for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent on use of your personal/children information at anytime, and we will explain the ramifications of that decision, and the process.

PATIENT AND GUARDIAN CONSENT

I / We have reviewed the above information that explains how your office will use my/our personal information, and the steps your office is taking to protect my/our information. I know that your office has a Privacy Policy, and I can ask to see the policy at any time. I agree that Dr. Pravin Patel Dentistry Professional Corp. can collect, use and disclose personal information about:

____

as set out above in the information about the office's privacy policies.

____________________	____________________
Signature	Print Name
____________________	____________________
Date	Witness