HEALTH HISTORY & REGISTRATION

MEDICAL ALERT

PATIENT INFORMATION

PATIENT'S NAME Last _____ First _____ Middle Initial _____ SEX: M F BIRTHDATE _____ AGE _____

If Patient is a Minor, give Parent's or Guardian's Name _____ TODAY'S DATE _____

Who May We Thank for Referring You to our Office? _____ Reason for this Visit _____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First _____ Middle Initial _____ MARITAL STATUS _____

RESIDENCE Street _____ Apt # _____ City _____ Province _____ Postal Code _____

MAILING ADDRESS Street _____ Apt # _____ City _____ Province _____ Postal Code _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____ BIRTHDATE _____ RELATION TO PATIENT _____

EMPLOYER _____ OCCUPATION _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ E-MAIL _____

Insurance Co. Address _____

Insured's Employer _____

Insured's SIN. # _____ Group # _____ Local # _____

EMERGENCY INFORMATION:

NAME _____ RELATIONSHIP _____

HOME PH. _____ CELL PH. _____

WORH PH. _____

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY	YES	NO
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam, Date:		
Last FULL MOUTH X-RAYS, DATE: (16 Small Films or Panoramic)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is your present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your dentures?	☐	☐
Would you like to know more about PERMANENT REPLACEMENT?	☐	☐
Are you APPREHENSIVE about dental treatment?	☐	☐
Have you had any PERIODONTAL (GUM) treatments?	☐	☐
Do your gums BLEED, or feel TENDER or IRRITATED?	☐	☐
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	☐	☐
Are you UNHAPPY with the APPEARANCE of your teeth?	☐	☐
Are you aware of GRINDING or CLENCHING your teeth?	☐	☐
Do you have HEADACHES, EARACHES, or NECK PAINS?	☐	☐
Have you worn BRACES on your teeth (ORTHODONTICS)?	☐	☐
Do you have DISCOLORED teeth that bother you?	☐	☐
Would you like your smile to LOOK BETTER or DIFFERENT?	☐	☐
Do you REGULARLY use DENTAL FLOSS?	☐	☐

Name of Previous Dentist?

City: Province:

How do you feel about your teeth?

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain # LACK of concern #

COST of treatment # MISSING work time #

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIAN'S CARE now?	☐	☐
For what?		
What MEDICATIONS are you currently taking?		
Are you PREGNANT? If applicable	☐	☐
Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	☐	☐

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	YES	NO		YES	NO		YES	NO
AIDS/HIV Pos.	☐	☐	Fainting	☐	☐	Psychiatric care	☐	☐
Anaphylaxis	☐	☐	Food allergies	☐	☐	Rapid weight gain/loss	☐	☐
Anemia	☐	☐	Glaucoma	☐	☐	Radiation treatment	☐	☐
Arthritis (Rheumatism)	☐	☐	Headaches	☐	☐	Respiratory disease	☐	☐
Artificial Heart Valves	☐	☐	Heart murmur	☐	☐	Rheumatic/scarlet fever	☐	☐
Artificial joints	☐	☐	Heart problems (please describe)	☐	☐	Shingles	☐	☐
Asthma	☐	☐	_____			Shortness of breath	☐	☐
Atopic (Allergy Prone)	☐	☐	Hemophilia (Abnormal bleeding)	☐	☐	Skin rash	☐	☐
Back Problems	☐	☐	Herpes	☐	☐	Spina Bifida	☐	☐
Blood Disease	☐	☐	Hepatitis	☐	☐	Stroke	☐	☐
Cancer	☐	☐	High blood pressure	☐	☐	Surgical implant	☐	☐
Chemical dependency	☐	☐	Jaw pain	☐	☐	Swelling of feet or ankles	☐	☐
Chemotherapy	☐	☐	Kidney disease or malfunction	☐	☐	Thyroid disease or malfunction	☐	☐
Circulatory problems	☐	☐	Liver disease	☐	☐	Tobacco habit	☐	☐
Cortisone treatments	☐	☐	Material allergies	☐	☐	Tonsillitis	☐	☐
Cough (persistent)	☐	☐	(latex, wool, metal, chemicals)			Tuberculosis	☐	☐
Cough up blood	☐	☐	Mitral valve prolapse	☐	☐	Ulcer/Colitis	☐	☐
Diabetes	☐	☐	Nervous problems	☐	☐	Venereal disease	☐	☐
Epilepsy	☐	☐	Pacemaker/heart surgery	☐	☐			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin	Latex (balloons,
Nitrous Oxide	Codeine	Penicillin	gloves, etc.)

Are you aware of being allergic to any other medications or substances?

If yes, list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN _____ PHONE _____ E-MAIL _____

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____

Financial Policy

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have questions, please discuss them with our financial team members.

The Dental Smile Centre is pleased to offer you the following payment options.

Option 1: Payment is due in full the day treatment is rendered. We accept cash, certified cheques, debit, Visa, and MasterCard.

Option 2: Your insurance company may require you to, or you may prefer to, pay for your dental work directly on your treatment day, and have your insurance company reimburse you. **The Dental Smile Centre** will process your payment on the date treatment was rendered. Our team members will assist you in submitting the necessary documents to your insurance carrier.

Option 3: You may leave your credit card number on file (secure database) and we will directly bill your insurance company, you don't have to wait around on your treatment day. Once your insurance company has paid us their portion, our Financial Advisors will process your patient portion to the credit card on file. The Dental Smile Centre can provide estimates when requested. Receipts can be mailed or emailed to you.

Appointment Policy

We respect that your time is valuable; therefore we make every effort to see our patients at their scheduled time. As a courtesy to our staff and other patients, if you are 15 minutes late for your scheduled appointment, we may need to reschedule you for another date and time.

We request that our patients ***call our office*** at least 48 hours prior to their scheduled time to cancel/rebook an appointment. Appointments that are cancelled with less than 48 hours notice, are considered a Broken Appointment and may be subject to a cancellation fee.

Privacy Policy

Personal Data Protection

Dental records are collections of sensitive personal patient information compiled to allow dentists and other dental health care providers to offer dental treatment, maximize continuity of care, and maintain optimal standards of care. Original dental records compiled by a dentist are the legal property of the dentist.

Patients have a legal right to examine and copy their records and to control the use and dissemination of the information contained in their records. Dentists require patients to provide complete, accurate and intimate health details in order to provide safe and effective treatment. Therefore, ownership of original dental records obligates the security and confidentiality of the information contained therein, which may be developed only with the permission of the patient except when otherwise required by law.

Patients have the right to control the disclosure of their dental records to others. Release of information must be informed; must be specific and for a one-time event; must afford the patient an opportunity to review the information being requested and released prior to its transfer, and with the opportunity to withdraw prior consent; must not be used for any purpose other than the primary and specific use requested; and must be done with the patient's permission, preferably in writing.

Patients are entitled to receive dental care in a confidential setting free of third party intrusion. Release of patient information to third parties must adhere to the basic principles of confidentiality and patient rights outlined above with the intention of enabling patients to review any and all third-party benefits to which they may be entitled. Patients may be unaware of the information that third parties may have access to under broad-based consents to release dental records, and the scope of this information may exceed the needs of a third party to determine benefits. It becomes the responsibility of the dentist and other dental health care providers to protect the confidentiality and privacy of their patients.

Where a third party (e.g., government agency, Canada Revenue Agency, dental association or insurance company) has received patient permission to use information from the patient's dental records for financial audits, all patient identity and unrelated information (e.g., health history, personal information) shall first be removed from the records. No third party can demand access to patient dental records (including financial records) except with specific patient consent in writing, by legal statute or by court order.

I have read and understand the financial, appointment policy and agree to abide by its terms. I also understand this policy may be amended from time to time by the practice. I have also read the office's privacy policy.

_____ _____

Signature of Patient (or guardian) Date

_____

Name of Patient (print)