NEW PATIENT INFORMATION FORM

Do you have a fever, difficulty breathing or a cough? YES ☐ NO ☐
Have you returned from travel in the last 14 days? YES ☐ NO ☐
Have you been in contact with a suspected or confirmed case of COVID-19? YES ☐ NO ☐
Are you experiencing pain or discomfort? YES ☐ NO ☐

PERSONAL INFORMATION

Today's Date: _____ **Full Legal Name:** _____

Address: _____

City: _____ **Postal Code:** _____

Date of Birth: _____ **Tel. No. (Home):** _____ **Tel. No. (Work):** _____

Tel. No. (Cell): _____ **Email Address:** _____

Emergency Contact: _____ **Emergency Contact Tel. No.** _____ **Relationship:** _____

Name of Primary Physician: _____ **Telephone No. of Primary Physician:** _____ **Date of Last Visit:** _____

How did you hear about us? _____

INSURANCE INFORMATION (IF APPLICABLE)

Primary

Subscriber Name: _____ **Insurance Company:** _____

Policy Group Number: _____ **Division:** _____

Certificate Number: _____ **Relationship to Insured:** _____

Secondary

Subscriber Name: _____ **Insurance Company:** _____

Policy Group Number: _____ **Division:** _____

Certificate Number: _____ **Relationship to Insured:** _____

MEDICAL HISTORY AND DETAILS

Have you been hospitalized or had a major operation within the last 2 years? **Yes** ☐ **No** ☐
If you indicated "Yes", please provide details: _____

Are you or could you be pregnant and/or breastfeeding? **Yes** ☐ **No** ☐
If you indicated "Yes", please provide details: _____

Do you have, or have you ever had, a heart condition or tested positive for a disease that could affect your immune system? (e.g. leukemia requiring chemotherapy) **Yes** ☐ **No** ☐

If you indicated "Yes", please provide details: _____

Please indicate which of the following you have had *or* have ever had:

AIDS/HIV Positive	**Yes** ☐	**No** ☐		**Head or Neck Injuries**	**Yes** ☐	**No** ☐	
Alzheimer's Disease	**Yes** ☐	**No** ☐		**Heart Attack/Failure**	**Yes** ☐	**No** ☐	
Anaphylaxis	**Yes** ☐	**No** ☐		**Heart Murmur**	**Yes** ☐	**No** ☐	
Anemia	**Yes** ☐	**No** ☐		**Heart Pacemaker**	**Yes** ☐	**No** ☐	

Arthritis/Gout	Yes ☐	No ☐		Heart Surgery	Yes ☐	No ☐		
Artificial Heart Valve	Yes ☐	No ☐		Hemophilia	Yes ☐	No ☐		
Artificial Joint	Yes ☐	No ☐		Hepatitis A/B/or C	Yes ☐	No ☐		
Asthma	Yes ☐	No ☐						
Blood Disease	Yes ☐	No ☐		High Blood Pressure	Yes ☐	No ☐		
Bruise Easily	Yes ☐	No ☐		Infective Endocarditis	Yes ☐	No ☐		
Cancer	Yes ☐	No ☐		Jaundice	Yes ☐	No ☐		
Chest Pains	Yes ☐	No ☐		Alcohol or Drug Dependency	Yes ☐	No ☐		
Circulation Problems	Yes ☐	No ☐		Liver Disease	Yes ☐	No ☐		
Diabetes	Yes ☐	No ☐		Lung Disease	Yes ☐	No ☐		
Emphysema	Yes ☐	No ☐		Mental/Nervous Disorder	Yes ☐	No ☐		
Epilepsy/Seizures	Yes ☐	No ☐		Organ/Medical Transplant	Yes ☐	No ☐		
Psychiatric Disorder	Yes ☐	No ☐		Prosthetic Joints	Yes ☐	No ☐		
Eating Disorder	Yes ☐	No ☐		Sickle Cell Disease	Yes ☐	No ☐		
Fainting	Yes ☐	No ☐		Stroke	Yes ☐	No ☐		
Glaucoma	Yes ☐	No ☐		Tuberculosis	Yes ☐	No ☐		
Gastrointestinal Disorders	Yes ☐	No ☐						

Additional comments and/or medical conditions (current or otherwise) not listed:

_____

Are you currently taking any prescription or non-prescription medication? Yes ☐ No ☐

If yes, please provide details:

_____

DENTAL VISITS AND DENTAL HISTORY

Are you nervous during dental visits or treatment?	Yes ☐	No ☐
Have you ever had an unfavourable dental experience?	Yes ☐	No ☐
Have you ever had complications from past dental treatment?	Yes ☐	No ☐
Have you ever experienced a dental operation or procedure of any kind?	Yes ☐	No ☐
Have you ever had trouble getting numb or had reactions to local anesthetic?	Yes ☐	No ☐
Do you bruise easily or bleed severely when cut?	Yes ☐	No ☐
Have you ever worn braces? If yes, at what age: _____	Yes ☐	No ☐
Have you ever had any teeth removed or had teeth that never developed?	Yes ☐	No ☐
Do your gums bleed or are they painful when brushing or flossing?	Yes ☐	No ☐
Have you ever been treated for gum disease?	Yes ☐	No ☐
Have you ever noticed an unpleasant taste or odor in your mouth?	Yes ☐	No ☐
Is there anyone with a history of periodontal disease in your family?	Yes ☐	No ☐
Have you ever experienced gum recession?	Yes ☐	No ☐
Have you had any cavities within the past 3 years?	Yes ☐	No ☐
Do you have difficulty swallowing any food?	Yes ☐	No ☐
Do you have problems with your jaw joint? (pain, sounds, locking, popping)	Yes ☐	No ☐
Do you feel or notice any holes on the biting surface of your teeth?	Yes ☐	No ☐
Are any teeth sensitive to hot or cold temperatures?	Yes ☐	No ☐
Do you avoid or have difficulty chewing gum, nuts, or other hard, dry foods?	Yes ☐	No ☐
Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	Yes ☐	No ☐
In the past 5 years, have your teeth or bite changed (shorter, thinner)?	Yes ☐	No ☐
Do you chew ice, bite your nails, or have any other oral habits?	Yes ☐	No ☐
Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	Yes ☐	No ☐
Do you wear or have you ever worn a bite appliance?	Yes ☐	No ☐

Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	Yes ☐	No ☐
Have you ever whitened (bleached) your teeth?	Yes ☐	No ☐
Have you felt uncomfortable or self conscious about the appearance of your teeth?	Yes ☐	No ☐
Have you been disappointed with the appearance of previous dental work?	Yes ☐	No ☐

How often do you see a dentist? Every: **3 months** ☐ **6 months** ☐ **12 months** ☐

Name of Last Dentist: _____ **Date of Last Visit:** _____

ALLERGIES

Are you allergic to, or have you had a reaction to, the following items?

Antibiotics	Yes ☐	No ☐
Aspirin	Yes ☐	No ☐
Codeine	Yes ☐	No ☐
Darvon	Yes ☐	No ☐
Local Anaesthetic	Yes ☐	No ☐
Nitrous Oxide	Yes ☐	No ☐

If you have ever been advised against, or had a reaction to, taking any type of medication, please list it:

_____

Please list any allergic conditions (e.g. asthma, hay fever, food allergies, latex allergy):

_____

CHILDREN UNDER THE AGE OF 18 ONLY:

Please list any medical conditions the child has recently had (e.g. measles, strep throat, tonsillitis etc.)

_____

CONSENT

COLLECTION OF PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality dental care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly. We collect personal information for the following purposes and mandate:

- **Only necessary information is collected about you;**
- **We only collect, use, and share your information with your consent;**
- **Storage, retention and destruction of your personal information complies with existing legislation;**
- **We continuously review our policies and privacy protection protocols on an ongoing, annual basis to ensure that we comply with our obligations under various provincial legislation;**
- **We confirm that our privacy protocols comply with provincial privacy legislation and standards of our provincial regulatory body, as amended from time to time.**

<u>This office will collect, use and disclose information about you for the following purposes, including:</u>

- **To deliver safe and efficient patient care and to identify and to ensure continuous high-quality service.**
- **To assess your health and dental care needs and to advise you of treatment options**
- **To enable us to contact you and to establish and maintain communication with you.**
- **To communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists.**
- **To maintain communication with you to provide health care information and to book/confirm appointments.**
- **To allow us to efficiently follow-up for treatment, care and billing.**
- **To comply with legal and regulatory requirements, including the delivery of patients' charts and records to our provincial regulatory body, in a timely fashion.**
- **To invoice for goods and services and to process credit card payments.**
- **To comply with our obligations under applicable federal and provincial privacy legislation.**

By signing the consent section of this Patient Consent Form below, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes included herein. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. 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 for your review, and for your specific consent. I have reviewed the above information that explains how your office will use and protect my personal information. I understand that I may withdraw my consent at any time, and, should I wish to do so, I will contact the clinic to inform them of this intention. I agree that my dental clinic or dental care provider, as outlined herein, can collect, use and disclose personal information for the purposes set out herein.

_____ _____

Date **Print Name**

_____

Signature

PATIENT ACKNOWLEDGEMENTS

CANCELLATION POLICY

It is the practice of our office to see all our patients on an appointment basis. We respect your time and make every effort to remain on schedule. We ask that you extend the same courtesy to us. If you are unable to keep your appointment, we request that you notify us at least 2 business days prior to your appointment. When you do so, we are able to offer your timeslot to another patient. Patients who fail to provide us with adequate notification time will be charged a missed appointment fee of $50.00.

If you have any questions or require clarification, please contact our office.

I have read and understood the Cancellation Policy as outlined herein. I agree to the terms described and assume full liability for any fees charged should I fail to abide by these short notice requirements.

_____ _____

Date **Signature**

INSURANCE INFORMATION RELEASE

I authorize my insurance company to provide coverage information or pre-determination information required by my dental clinic or dental care provider, as outlined here, in order to provide me and/or all my dependants on this plan with necessary dental treatment as required by me.

_____ _____

Date **Signature**

ELECTRONIC CLAIM AUTHORIZATION

I understand that my claims may be submitted electronically, and I authorize the release, to my dental benefit carrier, of information contained in claims submitted electronically.

Date _____ **Signature** _____