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Westheights Dental Centre

MEDICAL ALERT (FOR OFFICE USE)

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Privacy Act standards set up and monitored by our office. If you have questions please ask us.

New Patient's Information

Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.	**Given Name**	**Pronunciation**
Surname	**Prefer to be called**	**Gender** ☐ Male ☐ Female
Date of Birth *(mm/dd/yyyy)*	**Adult or Child?** ☐ Adult ☐ Child	**Marital Status**

Address *(Apt #, Street # & Name, City, Province, Postal Code)*

Home Phone #	**Mobile Phone #**	**Work Phone #** Ext.	**Fax #**
Email	**Preferred Contact Method**	**Occupation**	**Employer/School**

How did you hear about us? If person, specify name.	**Are you available on short notice for future appointments?** ☐ Yes ☐ No
Family Physician Name	**Family Physician Phone #**
In Case of Emergency, Notify:	**Relation** / **Phone #**

Person Responsible For This Account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other:

Name (if different from self)	**Home Phone #**	**Work Phone #** Ext.

Primary Insurance Information

Subscriber Name	**Subscriber ID**	**Date of Birth** *(mm/dd/yyyy)*	**SIN**	**Relation** ☐ Self ☐ Spouse ☐ Other:
Insurance Company	**Policy Plan #**	**Division/Sect. #**	**Are you familiar with your plan details?** ☐ Yes ☐ No	

Secondary Insurance Information *(if applicable)*

Subscriber Name	**Subscriber ID**	**Date of Birth** *(mm/dd/yyyy)*	**SIN**	**Relation** ☐ Self ☐ Spouse ☐ Other:
Insurance Company	**Policy Plan #**	**Division/Sect. #**	**Are you familiar with your plan details?** ☐ Yes ☐ No	

Medical History (All Information is Confidential)

The following information is required for the dentist to assist in proper diagnosis and treatment.

	YES	NO
1. Have you ever had a serious illness requiring hospitalization or extensive medical care?	☐	☐
If so, please specify: _____		
2. Are you presently under the care of a physician?	☐	☐
If so, please explain: _____		
3. Have you had a medical examination in the last year?	☐	☐
4. Do you use any prescription or non-prescription drugs regularly?	☐	☐
Please specify: _____		
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex?	☐	☐
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea?	☐	☐
Please specify: _____		

7. Have you ever experienced any unusual reaction to any of the following?

☐ Local Anaesthesia (freezing) ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulpha Drugs
☐ Barbiturates (sleeping pills) ☐ Other: _____

If so, please explain: _____

8. Have you been warned against taking any drug or medication?	☐	☐
9. Do you bruise easily or bleed abnormally?	☐	☐
10. Do you require pre-medication for dental treatment?	☐	☐

	YES	NO
11. Have you ever had any organ implants or medical implants?	☐	☐
12. Have you ever fainted?	☐	☐
13. Do your ankles swell?	☐	☐
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
15. Do you have frequent headaches?	☐	☐
16. Do you have AIDS or you have ever tested positive for HIV?	☐	☐
17. Do you have any of the following? Please check any that apply.	☐	☐

☐ Heart Murmur or Mitral Valve Prolapse	☐ Malignant Hyperthermia	☐ Epilepsy or Seizures	☐ Herpes
☐ Stomach / Intestinal Problems/Ulcers	☐ Drug/Alcohol Dependency	☐ Liver Disease	☐ Sinus Trouble
☐ Joint Replacement (hip, knee, etc.)	☐ Venereal Disease	☐ Heart Attack	☐ Stroke
☐ Mental or Nervous Disorder	☐ Lung Disease (i.e. Asthma)	☐ Cold Sores	☐ Kidney Problems
☐ High Blood Pressure	☐ Thyroid Disease	☐ Jaundice	☐ Emphysema
☐ Low Blood Pressure	☐ Arthritis or Rheumatism	☐ Tuberculosis	☐ Glaucoma
☐ Hyper (hypo) Glycemia	☐ Scarlet or Rheumatic Fever	☐ Hepatitis A,B,C	☐ Diabetes
☐ Cortison/Steroid Therapy	☐ Cancer / Chemotherapy	☐ Other: _____	

18. Have you had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐
19. Do you have any disease, condition, or problem you think the doctor should know about?	☐	☐
20. WOMEN ONLY – Are you pregnant or suspect you might be? If so, what month are you in? _____	☐	☐
Are you taking birth control pills?	☐	☐
Are you nursing?	☐	☐

Dental History	YES	NO
1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other: _____		
Do you presently having dental pain?	☐	☐
Is there a dental problem you would like to take care of as soon as possible?	☐	☐
2. How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other: _____		
3. How often do you brush your teeth? _____ Floss? _____		
4. Do your gums bleed easily?	☐	☐
5. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets ☐ Other: _____		
6. Do you feel you have bad breath at times?	☐	☐
7. Have you ever had jaw joint surgery?	☐	☐
8. Do you have pain in your jaw joints or suffer from migraine headaches?	☐	☐
9. Does any part of your mouth hurt when clenched?	☐	☐
10. Does your jaw crack or pop when opened widely?	☐	☐
11. Have you had (check any that apply): ☐ Braces ☐ Oral Surgery ☐ Gum Treatment ☐ Root Canal		
12. Do you grind or clench your teeth during the day or night?	☐	☐
13. Do you smoke? If so, specify number per day: _____	☐	☐
14. Do you or does any family member have a problem with snoring?	☐	☐
15. Have you ever experienced growths or sore spots in your mouth? If so, where? _____	☐	☐
16. Previous problems with dental treatment? Specify: _____	☐	☐
17. Are you satisfied with the appearance of your teeth? Specify: _____	☐	☐
18. Other Dental Concerns: _____		

Privacy Act Notification: I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.

Office Policy: Your appointment time will be reserved for you. **If you are unable to keep the appointment we will require 48 hours notice, otherwise a $50 charge is applied.**

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

Signature _____ ☐ Patient ☐ Parent ☐ Guardian

Date MM / DD / YY

Reviewing Dentist

Westheights Dental Centre

Financial Policy

At Westheights Dental Centre we strive for excellent service and care at the current fee guide established by the Ontario Dental Association (ODA FEE GUIDE) therefore, payment is required at each dental visit. We accept – Cash, Visa, Mastercard, and Interac. If you have dental insurance benefits, we will submit your claims electronically. Your insurance carrier will reimburse you at the percentage your coverage allows. Should you require extensive cosmetic or restorative dentistry you may qualify for special financial arrangements based on your dental treatment. Payments from your dental insurance may take from 2-6 weeks. We will do our best to help you understand your dental coverage plan, questions about fees and coverage should be answered by your carrier.

Cancellation Policy

All of our dental visits require preparation prior to your arrival, therefore; we require 2 business days should an appointment change be necessary so that we can replace the vacant spot to someone who needs treatment. As a courtesy, you will receive a confirmation call two days before your next dental appointment. All missed appointments or insufficient notice of cancellations may be subject to a fee, which must be paid before the appointment can be rescheduled. Please note that the insurances do not pay for missed or cancelled appointments.

Permission To Use Photographs And X-Rays

I consent to the taking of photographs and x-rays before, during and after dental treatment as they are a necessary part of the diagnostic procedure and record keeping. I further give permission for the use of these photographs, x-rays and records to be shown to other patients and doctors for treatment and education purpose.

Privacy Policy

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

In this office, Dr. Ghada Al-Shurafa is the contact person for personal health information related matters. All staff members who come in contact with your personal health 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 health 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.

Do not hesitate to discuss our policies with me or any member of our office staff.

How Our Office Collects, Uses and Discloses Patients' Personal Health Information

Our office understands the importance of protecting your personal health information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

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

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health needs

- to provide health care
- to advise you of treatment options
- 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 complex and dental care generally
- to communicate with other treating health care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- to allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit dental claims for third party adjudication and payment
- 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 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 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
- 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 (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.

Your personal health 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.

You may withdraw your consent for use or disclosure of your personal health information at any time.

Patient Consent

I have reviewed the above information that explains how your office will use my personal health information, and the steps your office is taking to protect my information.

I agree that Westheights Dental Centre can collect, use and disclose personal health information about

_____ as set out above in the information about the office's privacy policies.
[Patient Name]

_____ _____
Signature Date

_____ _____
Print name Signature of witness

Print Save Submit