WELCOME TO OUR DENTAL OFFICE

MEDICAL ALERT

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.

Mr. ☐ **Mrs.** ☐ **Miss** ☐ **Ms.** ☐ **Dr.** ☐ Given Name: ________ Marital Status: ________

Surname: ________ Pronunciation: ________ Prefer to be called ________

Address: (Street) (Apt. #) (City) (Postal Code)

Home Phone: ( ) - Work Phone: ( ) - X Date of Birth: MMM / DD / YY

Fax: ( ) - Other: ( ) - X ☐ Male ☐ Female ☐ Adult ☐ Child

Employer / School: ________ Occupation: ________

eMail Address: ________ Contact Method ________

Who may we thank for referring you to this office? ________

Are you likely to be available on short notice for future appointments ? ☐ Yes ☐ No

Family Physician: ________ Phone: ( ) -

In Case of Emergency Notify: ________ Relation: ________ Phone: ( ) -

Person responsible for this account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: ________

Name: (Last) (First) (Initial) Relation: ________

Address: (Street) (Apt. #) (City) (Postal Code)

Home Phone: ( ) - Work Phone: ( ) - X DRIVERS LICENCE NUMBER

Primary Insurance

Subscriber: ________ Date of Birth: ________

Relation: ☐ Self ☐ Spouse Other: ________

Subscriber I.D.: ________ SIN: ________

Insurance Co: ________

Policy/Plan #: ________ Division/Sect. #: ________

Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Secondary Insurance

Subscriber: ________ Date of Birth: ________

Relation: ☐ Self ☐ Spouse Other: ________

Subscriber I.D.: ________ SIN: ________

Insurance Co: ________

Policy/Plan #: ________ Division/Sect. #: ________

Are You Familiar with Your Plan Details? ☐ Yes ☐ No

Method of Payment: ☐ Cash ☐ Cheque ☐ Credit Card: ________ Number: ________ Exp.: ____

MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

The following information is required by 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? ☐ ☐
   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 been hospitalized in the last 5 years? ☐ ☐
   Please specify: ________
8. Have you ever experienced any unusual reaction to any of the following? (Please circle) ☐ ☐
   local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or any other medicine?
   If so please explain ________
9. Have you been warned against taking any drug or medication? ☐ ☐
10. Do you bruise easily or bleed abnormally? ☐ ☐
11. Do you require pre-medication for dental treatment? ☐ ☐

	YES	NO
12. Have you ever had any organ implants or medical implants?	☐	☐
13. Have you ever fainted?	☐	☐
14. Do your ankles swell?	☐	☐
15. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
16. Do you have frequent headaches?	☐	☐
17. Do you have A.I.D.S. or have you ever tested positive for H.I.V.?	☐	☐
18. 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
☐ Cortisone/Steroid Therapy	☐ Cancer / Chemotherapy	☐ Other: ______	

	YES	NO
19. Have you had any injury, surgery or x-ray therapy to your face or jaws?	☐	☐
20. Do you have any disease, condition, or problem that you think the doctor should know about?	☐	☐
21. 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: ______		
Are you presently having dental pain?	☐	☐
Is there a dental problem you would like to take care of as soon as possible?	☐	☐
Please specify: ______		
2. How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other: ______		
Last dental visit: ______		
Last cleaning: ______ Full mouth series of x-rays: ______		
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?	☐	☐
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: ☐ Braces ☐ Oral surgery ☐ Gum treatment ☐ Root canal	☐	☐
12. Do you grind or clench your teeth during the day or night?	☐	☐
13. Do you smoke? Number per day: ______	☐	☐
14. Do you or does any family member have a problem with snoring?	☐	☐
15. Have you ever experienced any 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?	☐	☐
Please 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 24 hours notice, otherwise it may be necessary to charge for the time lost.

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 dependants is mine, and I will assume responsibility for fees associated with these services.

______ Date: MMM / DD / YY ______

(Signature) ☐ PATIENT ☐ PARENT ☐ GUARDIAN REVIEWING DENTIST

Holland Street Dental

Patient Consent Form - Collection, Use and Disclosure of Personal Information

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

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I acknowledge and agree that staff at Holland Street Dental can collect, use, and disclose personal information about (patient's name) ______________________________________as set out above, and in accordance with the Privacy Code of the office.

_____________________________________ _______________

Signature of Patient or Parent/Guardian Date

If there is Insurance Coverage:

I authorize release; to my dental benefits plan administrator and the CDA, to release information contained in claims and preauthorizations submitted electronically and manually. I also authorize communication of information related to the coverage details and services described to the named dental office.

This authorization shall continue in effect until the undersigned revokes the same.

_____________________________________ _______________

Signature of Patient or Parent/Guardian Date

Assignment Of Benefits:

I hereby assign my benefits, payable from claims submitted electronically and manually, to Dr. Tonkikh and authorize payment directly to her.

This authorization shall continue in effect until the undersigned revokes the same.

I understand that Holland Street Dental is a third party company and that my insurance policy is an agreement between me, my employer and the insurance company. I understand that though Holland Street Dental has my plan on file and submits claims on my behalf, that I am ultimately responsible to know my plans details and guidelines and that I am financially responsible for any treatment not covered under those guidelines.

_____________________________________ _______________

Signature of Subscriber Date

Holland Street Dental

PATIENT COMMUNICATION AUTHORIZATION FORM

Date: ___________________

___________________________________ ___________________________________

Please ***print*** your name Please ***sign***

___________________________________ ___________________________________

Legal Representative Description of Authority

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ **Any of the Above**
- ☐ **None of the above** (opt out)

In signing this Communication Authorization Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We provide you this information with your knowledge and consent.

We would also appreciate knowing how you learned of us!

Please check the appropriate box below:

- ☐ Patient Referral (Who referred you?) ____
- ☐ Friendly Dental Employee Referral (Who referred you?) ___________________________________
- ☐ Website/Internet
- ☐ Radio
- ☐ Office Sign
- ☐ Friendly Dental Phone Call
- ☐ TV
- ☐ Newspaper
- ☐ Event/Festival/Show
- ☐ Other Advertisement
- ☐ Other ____

If you have checked more than one, please circle the most influential in your decision to come in.

____

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

____
Signature of Privacy Officer