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: _____	

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 acknowledge that I have reviewed and understand how Holland Street Dental collects, uses, and discloses personal information in accordance with its Privacy Code and applicable privacy legislation, including the Personal Health Information Protection Act (PHIPA) of Ontario. I understand that I may request access to the Privacy 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 office Privacy Code.

_____ _____

Signature of Patient or Parent/Guardian Date

If there is Insurance Coverage:

I authorize the release of information contained in claims and pre-authorizations, submitted electronically or manually, to my dental benefits plan administrator and the Canadian Dental Association (CDA). I also authorize communication of information related to the coverage details and dental services provided to Holland Street Dental.

This authorization shall remain in effect until revoked in writing by the undersigned.
*****Holland Street Dental Collects any applicable co-payment or balance not covered by private or government Insurance Plans*****

_____ _____

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 my insurance policy is an agreement between me, my employer (if applicable), and my 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 for understanding my plans details and guidelines and that I am financially responsible for any treatment not covered under those guidelines**.

_____ _____

Signature of Subscriber Date

Tel: (905) 551-9522
107 Holland St E., Suite 300, Bradford, ON L3Z 2B9 ▪ www.hollandstreetdental.ca ▪ info@hollandstreetdental.ca

Holland Street Dental

Patient Communication Authorization Form

HOW WE COMMUNICATE WITH YOU

Holland Street Dental communicates with patients for purposes related to dental care, including appointment reminders, treatment information, billing, insurance matters, and follow-up care. Communication may occur by phone, voicemail, text message, email, or secure electronic communication systems.

SECURE ELECTRONIC COMMUNICATION (DEFAULT)

To protect your privacy, the clinic uses secure electronic communication whenever personal health information is shared electronically. This may include radiographs (X-rays), treatment plans, insurance documents, referrals, or copies of dental records.

Secure messages are accessed through a protected web-based system and may require identity verification. No special software installation is required.

REGULAR EMAIL AND TEXT MESSAGING (NOT SECURE)

Regular email and text messaging are not secure methods of communication.

If you choose to receive personal health information by regular email or text message, you understand and accept the privacy risks associated with these methods.

YOUR CHOICE (PLEASE READ CAREFULLY)

☐ I prefer to receive personal health information by regular email or text message, despite the known privacy risks. I understand that I may request secure electronic communication instead or withdraw this preference at any time.
(If this box is NOT checked, the clinic will continue to use secure electronic communication by default for personal health information.)

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have read and understand how Holland Street Dental communicates with me, including electronically, and I understand my choices.

Patient or Parent/Guardian Name (Print): _____

Patient or Parent/Guardian Signature: _____ **Date:** _____

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 _____
Other (please describe) _____ _____

Signature of Privacy Officer

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