Rathburn Corner DENTAL

4159 Tomken Road, Mississauga, ON L4W 1J4
905.464.0400 ♦ info@rathburncornerdental.com

Your cooperation in completing this questionnaire is essential in order to provide you with dental care in a safe and efficient manner. All information is protected by the patient-doctor confidentiality. Our staff is available to assist you with the completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

The patient is an: ADULT ❑ CHILD ❑ ADULT UNDER GUARDIANSHIP ❑ Name of Guardian_____

Patient's name: _____
(last) (first) (initials) (preferred first name)

Address: _____
(street) (apt #) (city) (province) (postal code)

Primary phone# _____ Alternate phone# _____ Work phone# _____

E-mail: _____ What is the preferred way to contact you?_____

Date of Birth: ___/___/___ Sex: M❑ F❑ X❑ Occupation:_____ Marital Status:_____
D M Y

Person responsible for this account: _____ Are other family members patients here? Yes ❑ No ❑

How did you find about our office? Friend ❑_____ Flyer ❑ Internet ❑_____ Other ❑_____
(name) (website) (please specify)

INSURANCE

Please be advised that dental insurance or benefits is a contract between you, your employer and your insurance provider and any available benefits are determined by your individual policy. Under the Privacy Act, the majority of insurance providers will not provide our office with specific details regarding your coverage. We cannot influence how much of our fees your insurance will cover. Our objective as dental health care providers is to diagnose and recommend treatment according to each patient's particular needs. We do not know if your insurance will cover the treatment we propose, as this is only outlined in your policy handbook. If you need assistance with the handbook, we can help.

Do you have dental insurance? No ❑ Yes ❑ Multiple plans ❑

Insurance card with you? No ❑ (Payment required at time of treatment, we'll help with the paperwork for your provider to reimburse you)
Yes ❑ Please provide your insurance card(s) to reception to have it entered directly into your profile

Is your insurance coverage through a spouse or a family member? Complete the section below:

Policy holder name: _____ Policy holder DOB: ___/___/___ Relationship to patient _____
D M Y

EMERGENCY AND MD

In case of emergency, we should notify - Name: _____ Relationship: _____ Phone No:_____

Name of Family Doctor: _____ Phone or address: _____

Name of Medical Specialist: _____ Area of specialty: _____

Phone or address: _____

MEDICAL HISTORY

1. Are you currently being treated for any medical condition or have you been treated within the past year? Yes ❑ No ❑ Not sure ❑
   If yes, please explain _____
2. Do you have any unresolved health issues? _____ Yes ❑ No ❑ Not sure ❑
3. When was your last medical checkup? _____
4. Has there been any change in your general health in the past year? Yes ❑ No ❑ Not sure ❑
   If yes, please explain _____
5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? Yes ❑ No ❑ Not sure ❑
   If yes, please list _____
6. Have you ever been advised to take premedication before dental treatment? Yes ❑ No ❑ Not sure ❑

... continue to the next page

7. Do you have any allergies to medications, latex/rubber products, other (e.g. hay fever, foods, metals)? Yes ❑ No ❑ Not sure ❑

If you answered yes, please list:_____

8. Do you have a prosthetic or artificial joint? If yes, when was the surgery performed? _____ Yes ❑ No ❑ Not sure ❑

9. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? Yes ❑ No ❑ Not sure ❑

10. Do you have a bleeding problem or bleeding disorder? Yes ❑ No ❑ Not sure ❑

11. Do you take baby aspirin or other blood thinners on a regular basis? Yes ❑ No ❑ Not sure ❑

12. Have you ever been hospitalized for any illnesses or operations? Yes ❑ No ❑ Not sure ❑

13. Do you have or have you ever had any of the following? PLEASE CHECK!

❑ chest pain, angina	❑ pacemaker	❑ arthritis	❑ malignant hyperthermia
❑ heart attack	❑ bypass/angioplasty	❑ stomach ulcers	❑ severe headaches
❑ blood pressure problems	❑ tuberculosis	❑ inflamm. bowel disease	❑ psychiatric therapy
❑ shortness of breath	❑ lung disease, asthma	❑ thyroid disease	❑ eating disorder
❑ rheumatic fever	❑ steroid therapy	❑ kidney disease	❑ seizures (epilepsy)
❑ mitral valve prolapse	❑ diabetes	❑ liver disease	❑ drug/alcohol dependency
❑ heart surgery	❑ cancer	❑ osteoporosis medication	❑ sexually transm. disease
❑ congenital heart defect	❑ stroke	(bone strengtheners)	❑ autoimmune disease

14. Are there any conditions or diseases not listed above that you have or have had? Yes ❑ No ❑ Not sure ❑

If so, what? _____

15. Are there any diseases or medical problems that run in your family? Yes ❑ No ❑ Not sure ❑

(e.g. diabetes, cancer or heart disease) _____

16. Do you smoke or chew tobacco products? Yes ❑ No ❑ Not sure ❑

17. For women only: Are you breastfeeding or pregnant? Yes ❑ No ❑ Not sure ❑

If pregnant, what is the expected delivery date? _____

DENTAL HISTORY

When was your last dental visit? _____ What for? _____ When did you last have dental x-rays?_____

Have you seen a dentist regularly? Yes ❑ No ❑

Do your gums bleed when you brush or floss? Yes ❑ No ❑

Do any of your teeth ache? Yes ❑ No ❑

Do you have any pain when you chew? Yes ❑ No ❑

Do you have a bad taste or bad breath? Yes ❑ No ❑

Have you had any trauma to your jaws or face? Yes ❑ No ❑

Have you ever had implant surgery? Yes ❑ No ❑

Have you ever had jaw surgery? Yes ❑ No ❑

Are you nervous during dental treatment? Yes ❑ No ❑ If yes, why? _____

What would you change about your teeth? _____

How can we help? _____

To the best of my knowledge, the above information is correct. I consent to the dental procedures agreed to be necessary or advisable, including the use of local anesthetics and radiographs, as indicated, and I will assume responsibility for fees associated with those procedures.

_____ _____ _____

PATIENT/PARENT/GUARDIAN SIGNATURE DATE DENTIST SIGNATURE

DENTIST'S NOTES _____

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Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, cell-phone numbers, work telephone numbers, and e-mail addresses. (Collectively referred to as "Contact Information").
Contact Information is collected and used for the following purposes:

- To open and update patient files;
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts;
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies;
- To send reminders to patients concerning the need for further dental examination or treatment;
- To send patients informational material about our dental practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatments or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition and dental treatments (collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf;
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion;
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment;
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion;
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

Dental information may include x-rays, cast models, pictures and/or videos. These will be kept as a record of care and may be used for educational purposes in study club meetings, lectures, seminars, and professional publications (journals, magazines). If any of these are used in any publication or as part of a demonstration, the patient's name and other identifying information will remain confidential.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview staff as part of its regulatory activities in the public interest.

I consent to the collection, use and disclosure of my personal information as set out above.

_____	_____	_____
Date	Print Name (patient/legal guardian)	Signature

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FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for entrusting us with your personal dental needs. We are very proud of our knowledgeable, well-trained, and caring staff. You will find us dedicated to helping you maintain your optimum oral health.
Please take time to familiarize yourself with our office financial procedures and policies.

- Your dental insurance is a contract between you and your insurance company. We cannot guarantee payment or coverage of your claim. Insurance policies vary greatly. Therefore, owing to the complexity of Insurance contracts, **you are fully responsible for knowing your own insurance plan.** Treatment is recommended based on what you need, not on what you are covered for. As a courtesy, we will prepare and submit claims on your behalf. Full payment will be required if your insurance does not allow direct billing. We are happy to work with you to help you understand your dental benefits. We encourage you to bring in your insurance booklet so that we can review it with you.
- Balances are to be paid in full at each appointment, unless written financial arrangements are made in advance of your treatment. Please discuss payment options and fees with our staff, and they would be pleased to work with you to make the required arrangements.
- Provided 2-business days notice is given, no charge will be made for rescheduling an appointment. Otherwise a fee may be incurred. Once an appointment has been made, please remember this time has been reserved specifically for you. A 50$ fee will be applied to cover our expenses.
- We require a 50% deposit for major dental treatment (crowns, bridges, implants, removable appliances). If we have a valid preauthorization of benefits from your insurance provider, we will only require a deposit of the amount not covered. Any remaining balances are due on the day of service is complete.
- For your convenience, we accept the following forms of payment: cash, Visa, MasterCard, direct payment (Interac) or American Express. Personal cheques are not accepted.

YOUR FINANCIAL CONSENT

The patient/guardian agrees that he/she is fully responsible for payment of procedures performed in this office, including any treatment deemed not a covered benefit by any dental insurance the patient may have.
I certify I have read and understand the above.

_____	_____	_____
Date	Print Name (patient/legal guardian)	Signature

PAYMENT POLICY

As a courtesy, we will direct bill to your insurance. Please note that payment is expected at each appointment as determined by your insurance plan or lack thereof. A credit card number will be kept on file for any balances not covered by your plan. Should you choose to decline to provide us with the information, we will assume non-assignment for your dental plan. For your convenience, we offer the following methods of payment. Please check your preferred payment option.

❑ Visa ❑ MasterCard ❑ American Express

Name on card _____

Card #_____ Expiry: month ____ year _____

Signature _____