CONNORS FAMILY DENTISTRY - CONFIDENTIAL PATIENT REGISTRATION

Welcome to our dental practice. Please print clearly when completing the following important information.

Contact Information: Mr. / Mrs. / Ms / Miss / Dr. (please circle one) Other: ___________________________________

Surname:_________________________________First name:__________________________________Middle initial:____

Preferred name:________________________________ Birthdate M/D/Y: ____________________________________

Address:____

Home phone:_____________________ Cell phone:_____________________ Work phone:___________________

Preferred daytime contact number: (√) H___ C___ W___ Email:____

Emergency contact: ________________________________ Relationship to patient: _______________________________

Daytime phone:_________________________________ Cell phone:____

Responsible Party for treatment and financial considerations (Please complete all information if different from above)

Name:_______________________________________ Relationship to patient:________________________________

Address: ____

Home phone:__________________________________ Cell phone:____

Work phone:___________________________________ Preferred daytime contact number: (√) H___ C___ W___

If the patient is a minor and a custody/guardianship order is in place, please provide details as to which person can provide authorization for dental care: ____

I certify that the above information provided is correct. I agree to inform Connors Family Dentistry of any changes.

____ ______________________________

Signature of patient or parent/guardian of minor Date

Insurance Information

Policy holder:_____________________Relationship to patient:_______________________Birthdate M/D/Y:_________

Employer:___________________________Work phone:_____________Email:___________________________________

Address:____

Insurance company:________________________Group/Policy #:_________________Certificate/Div/ID #:___________

Coverage: Basic:______% limit: $________ Major:______% limit: $_________ Ortho:______% limit: $______________

Secondary Policy

Policy holder:_____________________Relationship to patient:_______________________Birthdate M/D/Y:_________

Employer:___________________________Work phone:_____________Email:___________________________________

Address:____

Insurance company:________________________Group/Policy #:_________________Certificate/Div/ID #:___________

Coverage: Basic:______% limit: $________ Major:______% limit: $_________ Ortho:______% limit: $______________

Many dental insurance plans allow us to submit claims electronically on your behalf. In order to do this we require your authorization.

I authorize the release of information contained in claims submitted electronically to my dental benefits provider. I also authorize the communication of information related to dental coverage and benefits to my dental insurance provider. If allowed, I also assign my benefits payable from claims submitted electronically and authorize payment directly to this dental practice.

____ ______________________________

Signature of Patient or Parent/Guardian of Minor for Insurance Date

CONNORS FAMILY DENTISTRY - CONFIDENTIAL PATIENT MEDICAL HISTORY

Physician's name:____ Phone #:_______________________________

1. Are you in good health? Yes ____ No ____ If no, please provide details:_____________________________________
____

2. When was the last time you had a medical examination?____

3. Are you presently receiving treatment for any illness? If yes, please provide details: ___________________________
____

4. Have you ever been hospitalized? If yes, please provide details:____
____

5. Do you have any heart or circulatory problems? Yes ____ No ____ Do you have a pacemaker? Yes ____ No ____

6. Have you ever had rheumatic fever? Yes ____ No ____ If yes, when________________

7. Have you ever been advised to take antibiotic pre-medication prior to dental treatment? Yes ____ No ____

8. Do you have allergies? Seasonal/hay fever ____ Food _____________________ Medication___________________
____ Other____

9. Are you presently taking any kind of medication? If yes, please specify:
Drug ________________________________ Reason ____
Drug ________________________________ Reason ____
Drug ________________________________ Reason ____

10. Have you ever had a reaction to any kind of medicine or dental local anaesthetic? If yes, please provide details:
____

11. Female patients – Are you pregnant or think you may be pregnant? Yes ___ No ___ Breastfeeding? Yes ___No ___

12. Please indicate below (√) if you presently have or have ever had any of the following:

__ AIDS/HIV
__ Alcohol or chemical dependency
__ Arthritis or Rheumatism
__ Artificial joints or valves
__ Asthma
__ Blood transfusion
__ Cancer/radiotherapy/chemotherapy
__ Diabetes
__ Eating disorders
__ Epilepsy/seizures
__ Fainting/dizzy spells
__ High/low blood pressure
__ Hyper/hypo glycemia
__ Kidney disease
__ Liver disease (Hepatitis/Jaundice)
__ Lung disease/chest pains
__ Mental or nervous disorder
__ Stomach ulcers
__ Stroke
__ Tuberculosis
__ Venereal/communicable disease

13. Do you smoke? If yes, how much per day?______________________ per week? ___________________________
14. Do you use chewing tobacco/other smokeless tobacco products? Yes ____ No ____ If yes, how often? _________
15. Do you grind or clench your teeth? Yes ___ No ___
16. Do you suffer from headaches____ earaches_____ or neck aches_____?
17. Is there any additional information related to your health that has not been addressed above?

____

_________________________________ _____________ ______________________________ ___________
Signature of Patient or Parent/Guardian of Minor Date Reviewed by Dr. Connors Date

For office use only - Medical history update (continued on back of page, if needed)

____Date_________________By________
____Date_________________By________
____Date_________________By________
____Date_________________By________

CONNORS FAMILY DENTISTRY - CONFIDENTIAL PATIENT DENTAL HISTORY

Patient's name:____ Date of Birth:__________________________

Reason for this visit:____

Last dental visit (date): _________________ Treatment provided at that time:________________________________

Frequency of dental visits:__________ Previous dentist (name and location): _________________________________

Have you had a complete series of dental films/x-rays taken? ________ Where?_______________________________

When? _____________________________ Can we request these be sent to this office?_______________________

Please indicate Yes (Y) or No (N) to the following:

Do your gums bleed while brushing or flossing? ____

Are your teeth sensitive to hot or cold? ____

Are your teeth sensitive to sweets or sour? ____

Do you feel pain in any of your teeth? ____

Have you ever had any head, neck or jaw injuries? ____

Have you ever experienced any of the following problems in your jaw?

- Clicking ____
- Pain (joint, ear or side of face) ____
- Difficulty in opening/closing ____
- Difficulty in chewing ____

Have you received oral hygiene instruction for the care of your teeth and gums? ____

Do you have frequent headaches? ____

Do you have any sores or lumps in or near your mouth? ____

Do you bite your lips/cheeks frequently? ____

Have you noticed any loosening of your teeth? ____

Does food get caught between your teeth? ____

Have you had periodontal (gum) treatment? ____

Have you had prolonged bleeding following extractions before? ____

Do you wear dentures or partials? ____
If yes, date of placement______________________

Do you have dental implants? ____
If yes, date of placement______________________

Have you had treatment from a dental specialist? ____
If yes, what type?______________________________

Have you had orthodontic treatment? ____
If yes, date of completion? _______________________

Do you clench or grind your teeth? ____

Have you had difficult extractions before? ____

Additional comments or concerns?

____

____

____

Dentist's notes: ____

____

____

_________________________________ ____________ ____________________________ __________
Signature of Patient or Parent/Guardian of Minor Date Reviewed by Dr. Connors Date

CONNORS FAMILY DENTISTRY - AUTHORIZATION AND RELEASE

I certify that I have read, understood, and informed myself about, and answered the medical dental questionnaire to the best of my knowledge, and I have not knowingly omitted any information. I hereby promise to inform Dr. Connors/Connors Family Dentistry of any change in the state of my health. I understand that providing incorrect health information can be dangerous to my health. I authorize Dr. Connors/Connors Family Dentistry to release any information, including the diagnosis and the third-party payers and/or health practitioners.

____ ________________________________

Signature of Patient or Parent/Guardian of Minor Date

For Non-Insured and Insured

I, the undersigned, consent to the performing of the dental and oral surgery procedures agreed to be necessary and advisable, including the use of local anaesthetic as needed**,** and will assume responsibility for fees associated with these procedures. I authorize and request my insurance company to pay directly to the dentist or dental group insurance otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all records of any treatment/examination rendered to me during the period of such dental care services. I authorize Dr. Connors/Connors Family Dentistry to submit my insurance claims electronically on my behalf.

____ ________________________________

Signature of Patient or Parent/Guardian of Minor Date

Cancellation / Missed Appointment Policy

We understand that unplanned issues can come up and you may need to cancel an appointment.
We respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.

Dr. Connors and our practice hygienist want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancelation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not canceled within 24 hours.

As of January 1, 2021, there will be a fee of $50 assessed if we do not receive a call to cancel an appointment.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy.
This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

____ ________________________________

Signature of Patient or Parent/Guardian of Minor Date

CONNORS FAMILY DENTISTRY - COLLECTION, USE AND DISCLOSURE of PERSONAL HEALTH INFORMATION

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. Connors 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 and/or your child;
- 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 staff. Please be assured that every staff person in our office is committed to ensuring that you and or your child receive the best quality dental care.

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/dental care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide dental treatment, care and services in relationship to the oral and maxillofacial complex
- 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
- To complete and submit dental claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of 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 & 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

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 our office will use my/my child's personal health information, and the steps our office is taking to protect my/my child's information.

I agree that Dr. Connors/Connors Family Dentistry can collect, use & disclose personal health information about myself and/or my child as set out above in the information about the office's privacy policies.

____ ______________________

Signature of Patient or Parent/Guardian of Minor Date

Email and Text Communication Consent

In an effort to improve our communication with our patients, we would like to send some of our communications to you through emails and texts. To comply with the Canadian Anti-Spam Legislation (CASL) our dental office would like to have your express consent to communicate in this manner. If you decide to opt in and continue receiving emails and texts please know that you may opt out at any time and withdraw your consent.

Please sign below to give us permission or cross out any part you would like to decline:

Yes, I consent to our family receiving information via email and text from Dr. Connors/Connors Family Dentistry

____ ______________________

Signature of Patient or Parent/Guardian of Minor Date

Email address: ____

Please print clearly