Patient Information

Name: _____ DOB: (dd/mm/yyyy) ____ / ____ / ____

Telephone: *home* _____ *cell* _____ *work* _____

eMail: _____ preferred contact method: _____

Address: _____

Street *city* *province* *postal code*

Healthcard: _____ Issuing Province: _____

Emergency Contact: _____

name *relation* *telephone*

Insurance _____

company *policy & ID n°* *holder's name* *DOB (dd/mm/yyyy)*

When was your last dental appointment? _____

What was done at that time? _____

Any specific concerns at this time? _____

How did you hear about us? _____

Privacy statement for patients and consent form

Privacy of our patient's personal information is important to us. We are committed to collecting, using, and disclosing personal information responsibly.

PERSONAL INFORMATION

Personal information for our purposes is; that information necessary for the provision of professional oral health care services provided to you, and information necessary to administer this dental practice. Personal information includes all that information provided by you to us on our patient information/health/medical history form at the first visit and any subsequent visits. Personal information may also include any information provided by you to us during the normal course of communication between patient and dental office staff. We will use and disclose only information provided to us by you or another person acting on your behalf.

INFORMATION PROTECTION

We are committed to protecting your personal information. We have established and implemented a variety of security measures to properly manage and safeguard your personal information from loss, theft and unauthorized access. Access to your personal information shall be on a "need to know" basis.

INFORMATION DISCLOSURE

Your personal information shall be disclosed to only those who have a need to know and the specific information disclosed shall be restricted to only that information relevant to the recipients need to know. Those who have a need to know include other dentists and health care providers (i.e. dental specialists, personal physicians). Further, the personal information disclosed to dental benefit providers is limited to only that personal information required by the provider. You may at any time designate any restrictions as to whom we may disclose your personal information or restrict the content of a disclosure.

INFORMATION RETENTION AND DESTRUCTION

We will retain your personal information for the period necessary to continue providing oral health services to you, and for its related administration. We will destroy information in a secure manner when the information is no longer necessary for the provision of oral health services and is not required to be retained for compliance with provincial or federal regulations or statutes.

YOUR ACCESS TO YOUR RECORDS

We are committed to providing you with open access to your personal information held by us. You may at any time ask us to see your records held by us and to request amendments to that information. We will provide access to you within a reasonable timeframe recognizing your desire for the information and our need to carry on our practice with limited interruption.

COMPLAINT PROCESS AND CONTACT

Should you wish to make a formal complaint regarding our privacy practices, or have any questions comments or concerns please do so in writing to our privacy officer, Yvette Weeks. We will be pleased to assist you.

CONSENT

Having read and understood the PRIVACY STATEMENT FOR PATIENTS, I consent to the collection, use and disclosure of my personal information as presented in the STATEMENT, subject to the restrictions identified below.

No Restrictions _____

RESTRICTED ACCESS - My personal information shall not be provided to the following individuals or organizations:

RESTRICTED INFORMATION - Personal information disclosed from the personal information collected, shall not include:

Completed by:

name *signature* *relation* *date (dd/mm/yyyy)*

Cancellation and Financial Policy

Outside of illness, emergency, or severe weather conditions, twenty-four (24) hours notice is required for cancelling or rescheduling appointments. A fee of $75 may be payable on cancellations without adequate notice and “no-shows”.

In the event of severe weather conditions, illness involving a critical staff member, or emergency situation at our office, we will notify you as soon as we are able. Our policy is to avoid endangering our staff and patients via exposure to these conditions in order to continue providing you with the best care we are able, Arrangements for rescheduling appointments will occur at your earliest convenience, with treatment priority given to those affected by the cancellation.

We strive to provide you with the finest oral health care in our office. To accomplish this we work with you and your insurance company to minimize your fees due at the time of evaluation and treatment, and to maximize your reimbursements.

For your convenience, we make every effort to direct bill your dental insurance company, if applicable. You will be responsible for the estimated portion of your consultation or treatment that we expect will not be paid by your insurance. This includes co-payments and services not covered by your particular insurance. We are pleased to offer many payment methods, including most major credit cards, Interac, and cheques.

Please be prepared to provide payment in full for any fees incurred during your visit that day. Occasionally payment plans can be arranged. Accounts in arrears 90+ days may be sent to a collections agency. If you have any questions or concerns regarding your initial or subsequent visits, do not hesitate to contact us. Our administrative staff is friendly and knowledgeable, and can answer your questions regarding insurance and financial issues.

Please remember to bring your insurance information with you for your first visit.

I have read the above, and agree and understand that I am responsible for all charges relating to my visit.

Completed by:

name *signature* *relation* *date (dd/mm/yyyy)*

Medical History

Do you have or have ever had the following:	No	Yes	Not sure	Notes
heart condition, murmur, or heart surgery?				
angina or chest pain?				
high or low blood pressure?				
shortness of breath climbing one flight of stairs?				
asthma, bronchitis, or emphysema?				
liver disease or problems including jaundice?				
infectious diseases (Hepatitis, HIV, TB)?				
bacterial infection resistant to antibiotics (MRSA, VRE)?				
CJD (mad cow) or family history of disease/carrier status?				
diabetes? If yes type I or type II				
thyroid problems?				
taken or used steroid containing drugs?				
taken osteoporosis or bone density medications?				
illicit substances other than marijuana?				
kidney or urinary problems?				
epilepsy or seizures?				
stroke or mini stroke (TIA)?				
abnormal bleeding or bruising?				
stomach or duodenal ulcers?				
indigestion, hiatus hernia, esophageal ulcers?				
rheumatoid arthritis or osteoarthritis?				
jaw joint problems?				
anxiety, depression, or mental illness?				
malignant hypothermia?				
If female, are you pregnant or breastfeeding?				
sleep apnea?				
snore loudly, feel tired or excessively fatigued during the daytime?				

List prescribed and non-prescribed medications, doses, and how often you take them

Name	Dose	Frequency	Notes

List any allergies (medication, antibiotics, latex, egg, others) and your reaction to these substances:

List any operations/surgeries you have had, including childhood surgeries such as ear tubes or tonsils:

Have you or other members of your family had problems with general anaesthetics (being put to sleep for procedures) other than nausea or vomiting? For example, malignant hyperthermia. Specify:

Do you have any family history of bleeding problems, heart diseases, diabetes, or cancer? Specify:

Have you been evaluated or treated in a hospital or E.R. in the last 12 months? If yes, specify reason:

Do you have any other health problems not listed above? Specify:

Do you or did you ever smoke or chew tobacco regularly? Y / N

If yes, how much? Do you still smoke or chew? Y / N

Are you interested in quitting tobacco? Y / N

Do you consume alcohol? Y / N

If yes, how much and how often?

Family Physician:

name *location* *telephone*

Pharmacy:

name *location* *telephone*

I certify that I have read and I understand the questions above and have completed this form to the best of my knowledge. I will not hold my dentist, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Completed by:

name *signature* *relation* *date (dd/mm/yyyy)*

Reviewed by:

name *signature* *date (dd/mm/yyyy)*

CONSENT FORM & WAIVER

I hereby give consent to Coburg Dentistry to provide an intraoral (inside your mouth) and extraoral (outside your mouth in the head and neck areas) examination to determine my treatment needs. Additional diagnostic records and tests may be necessary to provide a diagnosis and develop a treatment plan. These additional records and tests may include (but are not limited to):

- Radiographs (x-rays)
- Impressions
- Models and casts
- Intraoral and extraoral photographs

I understand that bodily tissues (e.g biopsies, extracted teeth) may be removed during the course of treatment. These materials may also be used for any of the purposes outlined below.
All records are the property of Coburg Dentistry. I understand that any and all records created in connection with my examination and treatment, including x-rays, impressions, models and casts, intraoral and extraoral photographs during the time of care at Coburg Dentistry may be used for teaching purposes, education, accreditation, examinations and research within the office. I consent to the use of these records for these purposes, which will include disclosing them to students, dental professionals and others who are not providing me with treatment or supervising those who are providing me with treatment.

I understand that I must comply with all of the clinic policies and procedures. I have read and understand the Clinic Polices & Patient Information document that has been made available to me at Coburg Dentistry.

Coburg Dentistry understands and respects the sensitive nature of the information that you have provided to us. The information is used in compliance with all applicable federal and provincial privacy legislation, the Nova Scotia Dental Board to provide optimal dental care to our patients.

I acknowledge that Coburg Dentistry has the authority to discontinue treatment if it has been deemed to be in the best interest of the parties involved.

No guarantees or assurance of successful treatment can be made. I understand that Coburg Dentistry will make every effort to provide the highest quality of care but there is a risk of failure. I release Coburg Dentistry from any legal claims for injury, damage or losses suffered while a patient at Coburg Dentistry.

Patient Name (print) _____ Signature of Patient _____

Guardian Name (print) _____ Signature of Guardian _____

Date (dd/mm/year) _____

Optional consent for the expanded use of patient records
In addition, I also consent to the use of records which may identify me through the use of photographs or other records that may identify me that have been taken as part of my treatment for continuing education purposes or publication outside of the confines of Coburg Dentistry. The purpose includes providing these records to individuals who are not involved in my treatment in any way, including seminars and lectures which involve dental professionals who may not be affiliated with Coburg Dentistry.

Sign below ONLY if you agree to the expanded use of your records for these purposes

Patient Name (print) _____ Signature of Patient _____

Guardian Name (print) _____ Signature of Guardian _____

Date (mm/dd/year) _____