SAGEWOOD DENTAL CARE

This questionnaire was designed to provide important facts regarding your health history that will assist in reaching a diagnosis and treating you safely. PLEASE PRINT.

PATIENT INFORMATION **TODAY'S DATE** (DD/MM/YY): ____ / ____ / ____

NAME:_____ Date of Birth (DD/MM/YY): ____ / ____ / ____

Address: _____ Email:_____

City:_____ Province:_____ Postal Code:_____

Phone CELL:_____ WORK:_____ HOME:_____

Medical Doctor: _____ Phone/Address_____

Medical Specialist: _____ Area of Specialty_____

Medical Specialist: _____ Area of Specialty_____

Emergency Contact (name + phone #):_____

How did you hear about us (ex. Google, coworker, signage, parents etc.)?_____

DENTAL INSURANCE

Policy Holder NAME: _____ Birthdate (DD/MM/YY): ____ / ____ / ____

Insurance Co:_____ Employer: _____

POLICY/GROUP#_____ ID#_____ DIV#_____

SECONDARY DENTAL INSURANCE (if applicable)

Policy Holder NAME: _____ Birthdate (DD/MM/YY): ____ / ____ / ____

Insurance Co:_____ Employer: _____

POLICY/GROUP#_____ ID#_____ DIV#_____

AUTO INSURANCE (if applicable)

Policy Holder Name_____ Relationship to Policy Holder_____

Policy Holder Address_____

POLICY#_____CLAIM#_____

Insurance Co._____ City of Branch Office_____

Adjuster name_____

Adjuster's Phone No (_____) _____-_____ ext_____ Adjuster's Fax No (____)_____-_____

ARE YOU ALLERGIC TO: (CHECK IF YES)

Penicillin ☐ Aspirin ☐ Anesthetic (Freezing) ☐ Codeine ☐ Latex ☐ Other ☐

LIST ANY MEDICATIONS CURRENTLY BEING TAKEN (PLEASE ATTACH SHEET FOR MORE SPACE)

MEDICATION	REASON	MEDICATION	REASON
1)_____	_____	4)_____	_____
2)_____	_____	5)_____	_____
3)_____	_____	6)_____	_____

ARE YOU CURRENTLY BEING TREATED FOR ANY MEDICAL CONDITION OR HAVE YOU BEEN TREATED WITHIN THE PAST YEAR? ☐ Yes ☐ No Explain if yes _____

WHEN WAS YOUR LAST MEDICAL CHECK UP? _____

DO YOU HAVE A FAMILY HISTORY OF (check if yes): ☐ Diabetes ☐ Cancer ☐ Heart Disease

ARE YOU NERVOUS ABOUT DENTAL TREATMENT? _____

HAVE YOU EVER HAD OR EXPERIENCED…(CHECK IF YES AND SPECIFY THE APPROXIMATE YEAR)

YES	CONDITION	NOTES
☐	Blood pressure problems	_____
☐	Chest pain (angina)	_____
☐	Shortness of breath	_____
☐	Heart attack	_____
☐	Stroke, TIA	_____
☐	Heart murmur	_____
☐	Rheumatic fever	_____
☐	Mitral valve prolapse	_____
☐	Heart surgery	_____
☐	Heart valve replacement	_____
☐	Pacemaker	_____
☐	Bleeding Problems	_____
☐	Pregnant/Breastfeeding	_____
☐	Asthma	_____
☐	Smoking/Vaping (past/present)	_____
☐	Drug/Alcohol/Cannabis use	_____
☐	Tuberculosis	_____
☐	Lung disease	_____

- ☐ Stomach ulcers _____
- ☐ Anorexia/Bulimia _____
- ☐ Autoimmune Disorders _____
- ☐ Arthritis _____
- ☐ Joint Replacement _____
- ☐ Steroid therapy _____
- ☐ Diabetes _____
- ☐ Thyroid disease _____
- ☐ Cancer/Cancer treatment _____
- ☐ Anxiety/Mental Health Issues _____
- ☐ Child/Spousal Abuse _____
- ☐ Seizures (epilepsy) _____
- ☐ AIDS/HIV/STD _____
- ☐ Hepatitis _____
- ☐ Kidney disease _____
- ☐ Osteoporosis meds (ex Fosamax, Actonel) _____
- ☐ Concussion/Head injury _____
- ☐ Car Accident _____
- ☐ Snoring/Sleep Apnea _____
- ☐ Alzheimer's/Dementia _____

CONSENT

1.Consultation with your medical doctor may be necessary to assure safe dental treatment
2.Some dental insurance companies request information such as copies of X-rays or specific dental information to determine coverage.
3.The patient (guardian) is responsible for all costs and should be reimbursed by their insurance carriers according to the contract of their dental plan.
To the best of my knowledge the above information is correct.

Patient Signature Date: DD/MM/YY

Dentist Signature Date: DD/MM/YY

PATIENT CONSENT FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, **Dr. Brian Yim** acts as the Privacy Information Officer.

All staff members who come in contact with your personal 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;
- we only share your information with your consent;
- storage, retention and destruction of your personal 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 office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality dental care.

How Our Office Collects, Uses and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal 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 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 care
- to advise you of treatment options
- to enable us to contact you
- to establish and maintain communication with you
- to offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- 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
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit dental claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the *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 and 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
- to comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the *Regulated Health Professions Act* (RHPA*)* for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defence of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

I have reviewed the above 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 agree that York & Bay Dental Office can collect, use and disclose personal information about _____ as set out above in the information about the office's privacy policies.

_____	_____
signature	print name
_____	_____
date	signature of witness

SAGEWOOD DENTALCARE
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Welcome to our office!
We believe in optimum communication with our patients; therefore, we ask that you please read the following information and ask any and all questions so we may help you fully understand our financial and appointment policies.

FOR PATIENTS WITH DENTAL BENEFITS:

Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claim forms. Please be aware that your coverage depends solely on what your employer wishes to purchase. Please understand that any assistance concerning what or how much coverage you have, whether by phone or mail, is for reference only and should not be your only basis for proceeding with treatment. We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can (including electronic claims submission). In addition, because of the inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when figuring your portion of the charges. We will file your primary claims for you and the payments from your primary will be assigned to you.

FINANCIAL AGREEMENT (FOR ALL PATIENTS):

Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility for payment of fees. Treatment is to be paid in full when services are rendered unless other arrangements have been discussed and finalized. This may be in the form of Cash, Debit, Visa, MasterCard, or Amex. In the event it should become necessary to place your account in the hands of an attorney or collection agency, you will be responsible to pay all costs of collection, including attorney's fees.

REGARDING APPOINTMENTS:

Our time is valuable and so is yours. Our commitment to you is:

- We always try to make appointments that are convenient for you.
- We will not ask you to make a schedule change unless it is an extreme emergency.
- We will always be conscious of your personal time and will try to start your dental appointments on time and complete your treatment as efficiently as possible.

Please understand that **we reserve chair time just for you** when you make an appointment with us. In an effort to continually provide quality service, we ask that you keep your reserved appointment as it is scheduled. Please give our office **48 business hours (or more)** notice if you need to change your appointment, or a $50 fee will be assessed to your account.

Please keep us informed of any changes to your health information as well as your address, phone, email or insurance information so that we may serve you in the best possible manner.

I have read and understand the above financial policies. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

X_____ _____
(Patient or Guardian signature) (Date)

X_____
(Print patient's name)