D.S. DENTISTRY

DR. DIMPLE SHARMA D.D.S.

CREATING HEALTHY SMILES

Suite # 5, Upper James St., Hamilton, Ontario, Canada · 905.385.5649 · hamiltondentalclinic.com · drdsdentistry1@gmail.com

Welcome — in an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. Please print or email us.

Patient Information

A parent or guardian will be responsible for decisions on my treatment ☐ Yes ☐ No

Name: _____ _____ _____
FIRST INITIAL LAST

Address: _____ _____ _____ _____ _____
STREET APT. CITY PROV. POSTAL CODE

Date of Birth: _____ _____ _____ Home Tel.: _____ Work Tel.: _____
D M Y

Emergency Contact: _____ Tel.: _____

Family Doctor: _____ Tel.: _____

Referring Doctor: _____ Tel.: _____

Financial Information

Method of payment: ☐ Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other

Person responsible for financial matters: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other

IF DIFFERENT FROM ABOVE

Name: _____ _____ _____
FIRST INITIAL LAST

Address: _____ _____ _____ _____ _____
STREET APT. CITY PROV. POSTAL CODE

Date of Birth: _____ _____ _____ Home Tel.: _____ Work Tel.: _____
D M Y

Driver's Licence / SIN: *For your privacy, please provide your Driver's Licence and SIN number at the office.*

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Primary Insurance

Ins. Company: _____ Tel.: _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID/SIN#: _____

Max Cov.: _____ % coverage for _____ Basic _____ Maj. Restorative _____ Orthodontic

Dental History

	YES	NO
1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Other _____		
2. How frequently do you see a dentist? ☐ 3–6 months ☐ Annually ☐ Other _____		
3. When was your last dental visit? _____ Last X-Ray? _____		
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____		
5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other _____		
6. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never		
7. Do your gums feel swollen or tender?	☐	☐
8. Do you have bad breath or a bad taste in your mouth?	☐	☐
9. Do your jaws crack, pop or grate when you open widely?	☐	☐
10. Do you grind or clench your teeth?	☐	☐
11. Do you have food catch between your teeth?	☐	☐
12. Have you ever had local anaesthetic (freezing)? Any complications? ☐ Yes ☐ No Specify _____		
13. Have you ever had any problems with previous dental treatments? Specify _____		
14. Have you ever had any of the following:		
☐ Bridgework ☐ Crowns or Caps ☐ Full or Partial Dentures		
☐ Orthodontic (braces) ☐ Periodontal (Gums) ☐ Root Canal		
15. Are you satisfied with your teeth? Specify _____	☐	☐

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Medical History (this information will remain confidential)

Date

	YES	NO
1. Are you presently under the care of a physician? If so, explain	☐	☐
2. Have you ever been hospitalized? Explain	☐	☐
3. Are you taking any drugs or medication at this time?	☐	☐

A) Drug _____ Reason _____

B) Drug _____ Reason _____

C) Drug _____ Reason _____

4. Have you ever had any adverse effect to any of the following:

☐ Antibiotic–Penicillin ☐ Sulfonamide ☐ Other ☐ Aspirin ☐ Barbiturates (sleeping pills)
☐ Codeine ☐ Darvon ☐ Local Anaesthetic ☐ NONE

5. Have you ever been warned against using any other medications? Which?	☐	☐
6. Have you ever taken prolonged medical or non-medical drugs? Which?	☐	☐
7. Do you suffer from any allergies (hay fever, latex etc.)? Which?	☐	☐
8. Do you bruise easily or have prolonged bleeding?	☐	☐
9. Do you smoke? How much per day?	☐	☐
10. Have you ever fainted, had shortness of breath or chest pains?	☐	☐

11. WOMEN Are you pregnant? ☐ Yes ☐ No Using birth control? ☐ Yes ☐ No Reached menopause? ☐ Yes ☐ No

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Medical History (continued)

12. Do you have or have you ever had any of the following? Please check appropriate boxes. ☐ NONE

☐ A.I.D.S.	☐ Cortisone/steroid	☐ High/Low Blood pressure	☐ Psychiatric disorders
☐ Anemia	☐ Diabetes	☐ H.I.V. Positive	☐ Radiation/Chemotherapy
☐ Angina pectoris	☐ Drug/alcohol dependence	☐ Hodgkin disease	☐ Rheumatic/Scarlet fever
☐ Anorexia nervosa	☐ Emphysema	☐ Hyper (Hypo) Glycemia	☐ Sickle Cell disease
☐ Artificial Heart valve	☐ Epilepsy	☐ Hypertension	☐ Sinus trouble
☐ Arthritis/rheumatism	☐ Glandular disorders	☐ Jaundice	☐ Stomach/intestinal problems
☐ Artificial joints (hips, knees)	☐ Glaucoma	☐ Kidney disease	☐ Stroke
☐ Asthma	☐ Head/Neck injuries	☐ Liver disease	☐ Thyroid disease
☐ Blood disorders	☐ Heart disease/attack	☐ Leukemia	☐ Tuberculosis
☐ Bronchitis	☐ Heart murmur	☐ Lung disease	☐ Ulcers
☐ Bulimia	☐ Heart pacemaker/surgery	☐ Malignant hyperthermia	☐ Venereal disease
☐ Cancer	☐ Heart rhythm disorder	☐ Mental/nervous disorder	☐ Other _____
☐ Circulation problems	☐ Hepatitis A/B/C	☐ Mitral valve prolapse	☐ Other _____
☐ Congenital heart lesions	☐ Herpes	☐ Organ transplant/implant	

13. CHILDREN Have you recently had any of the following (approximate date)?

☐ Chicken Pox _____ ☐ Measles _____ ☐ Mumps _____

☐ Strep Throat _____ ☐ Tonsillitis _____ ☐ NONE

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ☐ Patient ☐ Parent/Guardian | Print name | Date

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Patient Privacy Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality 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, the Privacy Information Officer is: **Dr. Dimple Sharma**

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.

In 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 protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body 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 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 below 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
- to communicate with other treating health-care providers, including specialists and referring doctors
- 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 claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies 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 governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to evaluate the 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 office'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

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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) 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 D.S. Dentistry can collect, use and disclose personal information about

(NAME OF CLINIC OR DOCTOR)

_____ as set out above in the information about the office's privacy policies.

(PATIENT'S NAME)

Signature _____ Print Name _____

Date _____ Signature of Witness _____

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Patient Financial Obligations

Our office (D.S. Dentistry) will, in some cases, accept the assignment of benefits (direct payment) from your insurance company. This policy does not absolve the patient of full responsibility for the charges in full for the treatment(s) rendered.

1. The patient is responsible for knowing the type and the amount of coverage that his/her policy provides.
2. When coverage is limited to a percentage less than 100% or the fees paid by the insurance company are not current (e.g. 80% reimbursement, and/or 1 to 5 yr behind fee schedule), then the patient is asked to pay this estimated amount at the completion of the treatment; any adjustments if needed will be made after the patient's insurance payment is received.
3. The patient portion of the payment must be kept current or the assignment will be cancelled and the full amount will become due and payable after each service is provided.
4. Claims will be submitted promptly to your insurance company. Unfortunately, due to our own costs, we cannot wait more than 60 days for payment; therefore any outstanding balances on your account will be billed to you after 60 days, at which time payment is due in full.

Our staff will be available to service you at any time to answer any questions you may have.

FINANCIAL CONSENT

I the patient agree to be fully responsible for total payment for services rendered, including treatment that may not be covered by the insurance company. I certify that I have read, understand and agree to this.

Patient Signature _____ Date _____

Dentist/Reception Signature _____ Date _____