Orleans Family Dentistry

Patient Registration

Name: _____ Date of birth: _____

Address: _____

City/Province: _____ Postal Code: _____

Tel Contact Home:_____ Mobile: _____

Work/ Others: _____E-mail: _____

Whom may we thank for referring you to our office: _____

( ) Website ( ) Yellow Pages ( ) Sign

Emergency Contact Number

Name: _____Relationship: _____

Day-time contact: _____Other contact: _____

Name of Physician: _____Contact: _____

Name of Physician: _____Contact: _____

Previous Dentist Information

Previous Dentist: _____

Previous Dentist telephone: _____

When was you last dental visit? _____

When did you last have dental x-rays taken? _____

Insurance Information

Private Insurance: YES NO

Primary Benefit Information

Insurance Company: _____
Name of Insured: _____D.O.B: _____

Relationship to Insured: Self Spouse Child Other

Group #/ Subscriber ID: _____

Secondary Benefit Information

Insurance Company: _____
Name of Insured: _____D.O.B: _____

Relationship to Insured: Self Spouse Child Other

Group #/ Subscriber ID: _____

Orleans Family Dentistry

Medical History

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

- Are you being treated for any medical physical & mental condition at the present or have you been treated within the past year? If yes, why?

  _____

  _____

- When was your last medical check-up? (dd/mm/yyyy) _____
- Have there been any changes in your general health in the past year? If yes, please explain.

  _____
- Are you taking any medications, non-prescribed drugs or herbal supplements of any kind? If yes, please list: _____

  _____
- Do you have any allergies? If you answered yes, please list using the categories below:
  YES NO Not Sure

  i) Medications: _____

  ii) Latex/Rubber Products: _____

  iii) Others (e.g. Hayfever, Foods) _____
- Have you ever had a peculiar or adverse reaction to any medicines or injections?

  YES NO Not Sure

  If yes, please explain: _____
- Do you have or have you ever had asthma? YES NO Not Sure

  If yes, type of puffer: _____
- Do you have or have you ever had any heart or blood pressure problems?

  YES NO Not Sure
- Do you have or have ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? YES NO Not Sure
- Have you ever had hepatitis, jaundice or liver disease? YES NO Not Sure

  If yes, which type of hepatitis?_____
- Do you have a prosthetic or artificial joint? YES NO Not Sure

  If yes, please explain: _____

Orleans Family Dentistry

l) Have you ever been advised by your doctor to take antibiotics before every dental treatment?
YES NO Not Sure

If yes, please state name of PreMed and last prescribed: _____

_____

_____

- Do you have a bleeding problem or bleeding disorder? YES NO Not Sure

  If yes, please explain: _____

- Have you ever been hospitalized for any illness or operations? YES NO Not Sure

  If yes, please explain: _____

- 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

  If yes, please explain: _____

Do you have or have you ever had any of the following? Please check

- Alzheimer's
- Angina
- Anemia
- Arthritis
- Blood Transfusion
- Cancer
- Chest Pain
- Cold Sores
- Diabetes Type 1
- Diabetes Type 2
- Digestives Disorders/ Acid Reflux
- Drug/ Alcohol Dependency
- Emphysema
- Epilepsy or Seizures
- Fibromyalgia
- Head/ Neck Injury
- Heart Attack
- Heart Murmur
- High/ Low Blood Pressure
- Hodgkin's Disease
- Hypo/ Hyperglycemia
- Kidney Disease
- Lung Disease
- Lupus
- Migraines
- Mitral Valve Prolapse
- Osteoporosis Medications

  (e.g. Fosamax, Actonel)
- Pacemaker
- Parkinson's Disease
- Radiation/ Chemotherapy
- Rheumatic Fever
- Sexually Transmitted Infection
- Shortness of Breath
- Steroid Therapy
- Stomach Ulcers
- Stroke
- Thrush

- ○ Thyroid Disorder
- ○ TMJ Disorder
- ○ Tuberculosis
- ○ Depression
- ○ Anxiety
- ○ Schizophrenia

- Are there any conditions or disease not listed about that you have or have had?
  YES NO Not Sure

  If yes, please list: _____

- Are there any disease or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) YES NO Not Sure

  If yes, please explain: _____
- Do you smoke or chew tobacco products? YES NO Not Sure

  If yes, please explain: _____
- Are you nervous during dental treatment? YES NO Not Sure

<u>For women only:</u>

- Are you pregnant or breast-feeding? YES NO
  i. If pregnant, what is the expected delivery date? _____

_____

Orleans Family Dentistry

Your Personalized Smile Evaluation

Please take a moment to look at your teeth and gums carefully and then answer the following questions. Your answers are personal and held in strict confidence.

I am concerned about the appearance of my teeth or my smile	YES	NO
I am concerned about the whiteness/lack of whiteness of one or more of my teeth	YES	NO
I am concerned about the positions or angle of one or more of my teeth	YES	NO
In social situations, I am sometimes embarrassed by my teeth or my smile	YES	NO
There are some things about my upper front teeth that I would like to change	YES	NO
There are some things about my lower front teeth that I would like to change	YES	NO
I have old fillings or previous dental treatment that is no longer satisfactory to me	YES	NO
I am missing one or more of my teeth	YES	NO
I am interested in learning more about cosmetic dentistry	YES	NO

To the best of my knowledge, the above information is correct:

Patient/Parent/ Guardian signature: _____ Date: _____

Dentist signature: _____ Date: _____

Orleans Family Dentistry

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. Bhatia and Dr. Cadieux acts as the Privacy Information Officer.

All staff members who come in contact 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.

Orleans Family Dentistry

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 defense 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.

Orleans Family Dentistry

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 Dr.Bhatia and Dr. Cadieux 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

Orleans Family Dentistry

Appointments

Please be on time

Dr. Bhatia and Dr. Cadieux understands that patients are very busy, that their time is precious and that they do not like waiting.

Dr. Bhatia Dr. Cadieux tries as much as possible to respect the time of her patients. Due to unforeseen emergencies, the waiting time may vary.

Dr. Bhatia and Dr. Cadieux asks that you arrive on time for your appointment. If you arrive late, this means that all the patients booked after you will have to wait.

Therefore, if you arrive late for your appointment, do not always expect to be seen; if time permits, you will be seen, otherwise the receptionist will offer you another appointment.

Important!

If you cannot come to your appointment, please call to let us know 48 business hours in advance.

Policy regarding no shows

A notice of 48 business hours is required if you wish to cancel your appointment. If you fail to notify us, you will be charged $35.

_____

(Patient and/or Guardian)

Date: _____

Orleans Family Dentistry
2894 St-Joseph Blvd
Orleans On
K1C 1G7
info@orleansdentist.ca
Tel: 613-830-4444 Fax: 613-830-4451

Date (dd/mm/yyyy): _____

Former Dentist : _____

Phone : _____Fax :_____

Dear Dr. _____

_____has recently become a patient of our practice. We would like to request copies of their photographs be forwarded to us. Furthermore, if you would kindly provide us with the following information in order to help us in servicing this patient's dental needs.

Date of new patient exam (ei. 01103) :_____

Date of last recall exam (ei 01202-11101-11111) : _____

Date of last bitewing radiographs: _____

Date of last panoramic radiograph: _____

Date of fillings done in the past 24 months:_____

Crown/ Root canal treatment done in the past 24 months:_____

Thank you in advance for allowing us to continue treatment for your patient with the same care and concern.
Sincerely,

Orleans Family Dentistry
Dr. Maryse Cadieux/ Dr. Sunita Bhatia

I hereby authorize the release of my dental records and radiographs to Orleans Family Dentistry.

Patient/Parent's signature_____