BRAMPTON CITY CENTRE DENTISTRY

First Name | Last Name | Initials

Address | City | Province | Postal code

Home Number | Cell Number | Work Number

DOB (DD/MM/YEAR) | Family Physician | Family Physician's Phone Number

Emergency Contact Number | Email Address | Employer Name

INURANCE INFORMATION

Insurance Company Name | Policy/Group/Contract Number | Member ID

Member Name | DOB (DD/MM/YEAR) | Relationship to member

MEDICAL HISTORY

Please see say YES or NO to each question. If unsure of a question, please consult with the dentist YES NO

1. Are you being treated for any medical condition at present or within the past two years? If yes please YES NO
Explain: _____

2. When was your last visit to a Physician? _____ Last complete Physical Examination_____

3. Have you recently, or are you presently, taking any prescription or non-prescription drugs Incl.herbal YES NO
Remedies _____

4. Have you ever reacted adversely to any medications or injections? (Please circle) e.g. Penicillin, Amoxicillin or other antibiotics aspirin, codeine, local anesthesia (Freezing), nitrous oxide, or any other medicine

5. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or latex allergies, Skin Rashes? YES NO

6. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? YES NO

7. Have you ever had any injury or surgery to your face or jaws? YES NO

8. Are you pregnant or suspect may be? _____ / N/A Expected delivery date_____/ N/A

INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD

A.I.D.S	☐	Emphysema	☐	Jaundice	☐		
Anemia	☐	Epilepsy or Seizures	☐	Kidney disease	☐		
Arthritis/rheumatism	☐	Fainting or dizzy spells	☐	Liver disease	☐		
Artificial heart valve	☐	Glandular Disorder	☐	Lung disease	☐		
Artificial Joints (hip, Knee)	☐	Glaucoma	☐	Lupus	☐		
Blood disorders	☐	Heart Murmur	☐	Malignant Hyperthermia	☐		
Bronchitis	☐	Heart Pacemaker	☐	Mental/nervous disorder	☐		
Cancer	☐	Heart surgery	☐	Organ transplant	☐		
Circulation Problems	☐	Hepatitis A B C	☐	Radiation Treatment/Chemotherapy	☐		
Congenital heart lesions	☐	High/Low blood pressure	☐	Sinus Trouble	☐		
Cortisone Disease	☐	Hypertension	☐	Thyroid disease	☐		
Diabetes	☐	Inflammatory bowel Disease	☐	Stroke	☐		
				Tuberculosis	☐		
				None	☐		

When was your last dental checkup _____ what's the concern for today's appointment_____

I understand, certify that I have provided an accurate and complete personal and medical –dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that responsibility for payment of the dental services for myself and my dependent is mine, and I assume responsibility for fees associated with these services.

Patient/Parent/Guardian Signature | Dentist Signature | Date

BRAMPTON CITY CENTRE DENTISTRY

CONSENT FORM

We are committed to protection the privacy of our patient's personal information and to utilizing all personal information in a responsible and professional manner. This document summarize some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home address, home telephone numbers, work telephone numbers, and email addresses. (Collectively referred to us "Contact Information).Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process Claims for payments or reimbursements from third party health benefit providers and insurance companies
- To send the reminders to the patients concerning the need for further dental examination or treatment.
- To send patients informational material about our dental practice.

Contact information is disclosed to third party health benefit providers and insurance companies where the patients has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information is collected for payments processing purposes.

We collect information from our patients about their health history, their family health history, physical condition and dental treatments. (Collectively referred to us "Medical information) Patients' Medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient's Medical information is disclosed:

- To third party health benefit providers and insurance companied where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.
- With the consent of the patient, to other dentists and dental specialists, or to other health care professional.
- IF we ever considering selling all or part of our dental practice , qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take step to ensure that the prospective purchaser safeguard all personal information.

I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy.

_____ _____

Patient's signature Date