Name: _____ **Birthdate :** _____
Last First Day/Month/Year

Address:_____
Street City Postal Code

Phone: Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ **Do you have dental benefits?:** Yes No

Insurance Company: _____ **Employer:** _____

Policy Holder Name: _____**Birthdate:** _____

Policy #: _____ **I.D.#:** _____

Family Physician: _____

Emergency Contact: Name: _____ **Relationship:** _____

Telephone: _____

How did you hear about our office? _____

MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible dental care.

1. Are you being treated for any medical condition at the present time or have you been treated in the past year? ..... Yes No
2. Has there been any change in your general health in the past year?..... Yes No
   If yes, please explain: _____
3. Are you currently taking any **medication,** non-prescription drugs or herbal supplements of any kind? ..... Yes No
   Please specify medications: _____
4. Do you have any **allergies**? (e.g. penicillin, latex etc)..... Yes No
   Others please specify: _____
5. Have you ever had a peculiar or adverse reaction to any medicines or injections? Yes No
   If yes, please explain: _____
6. Do you bleed or bruise easily? ..... Yes No
7. Do you have or have you ever had a heart problem of any kind?..... Yes No
   Explain: _____
8. Have you ever had a heart murmur, mitral valve prolapse or rheumatic fever ..... Yes No
9. Do you have a prosthetic or artificial joint? ..... Yes No
10. Have you ever been advised by your doctor to take **antibiotics before dental treatment**?..... Yes No
11. Do you smoke or chew tobacco products? ..... Yes No
12. **Women only**: Are you pregnant or breast-feeding? .....Yes No
13. Have you ever been hospitalized for any illness or operations?.....Yes No
    Explain: _____

Do you now have or have you ever had any of the following? Please CHECK only those that apply.

__Aids/HIV __Heart Attack __Hip Replacement Surgery __Stomach Ulcers
__Anemia __Epilepsy (seizures) __Knee Replacement Surgery __Stroke
__Arthritis/Rheumatism __Drug/Alcohol Dependency __Kidney Disease __Thyroid Problem
__Asthma __Fainting __Hepatitis, Jaundice or Liver Disease
__Blood Disease __Pacemaker __Lung Disease __Venereal Disease
__Cancer __Head Injuries __Mental Disorder __ Tuberculosis
__Diabetes __High/Low Blood Pressure __Prosthetic Heart Valve __Chest pain/Angina
__ Shortness of Breath Other condition not listed: _____

TURN OVER >>>>

DENTAL HISTORY

1. When was your last dental visit? _____
2. Have you ever had any complications/problems with past dental treatments? ... Yes No
   Please explain: _____
3. Have you ever had a bad reaction to local anesthetic (freezing)? ..... Yes No
4. Are you nervous or anxious during dental treatment? .....Yes No
5. Have you ever used a form of sedation for dental treatment? ie.Nitrous Oxide (laughing gas), Oral Sedatives.. .... Yes No
6. Are your teeth sensitive to: __Cold __Sweets __ Heat __ Other
7. Do your gums bleed when brushing or flossing? ..... Yes No
8. Do your gums feel swollen or tender? ..... Yes No
9. Does food lodge between your teeth? ..... Yes No
10. Does your jaw crack, pop or grate when opened widely? ..... Yes No
11. Do you grind or clench your teeth? ..... Yes No
12. Reason for today's visit: _____

** OFFICE POLICY **

FINANCIAL POLICY:
Payment is due, in full, on the day of treatment or on upon the start of major treatment. If you have dental benefits on assignment to *Kent Place Dental Centre* any amount not covered by your benefits is due at each appointment. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. **You are ultimately responsible for all costs incurred regardless of what your dental insurance covers.**

APPOINTMENT POLICY:
When you make an appointment with our office, we reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us **1 business day or 24 hours notice** if you cannot keep an appointment. Appointment changes with **less than 1 day notice may be subject to a service fee.**

AUTHORIZATION AND GENERAL CONSENT
I agree and consent to a dental examination by Dr. Kambiz Koosha or an Associate of Kent Place Dental Centre.
I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

RELEASE OF INFORMATION
I authorize KENT PLACE DENTAL CENTRE to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals as required.

ASSIGNMENT OF INSURANCE BENEFITS
I authorize and request my insurance company to pay my benefits directly to Dr. Kambiz Koosha and Associates.

I have read and fully understand the above conditions of treatment and I accept my responsibility as a patient at this office.

_____ _____
Signature of Patient (parent or guardian if minor) Today's Date

NEXT PAGE >>>>

PATIENT CONSENT FORM

FOR COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

We understand the importance of protecting your personal information and are committed to collecting, using and disclosing it responsibly. All our staff members are aware of the sensitive nature of information you disclose to us and are trained in the appropriate uses and protection of your privacy. **Kent Place Dental acts as Privacy Information Officer.**

In this consent form we outline what we are 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 privacy legislation and standards of our regulatory body, The Royal College of Dental Surgeons of Ontario

We have outlined below how our office is using and disclosing your information:

- to deliver safe, efficient and high quality patient care
- to asses your health needs and advise you of treatment options
- to contact you to book/confirm appointments and to allow us to follow-up on treatment and billing
- to provide treatment options, care and services in relationship to oral and maxillofacial health and dental care in general
- to communicate with healthcare providers; specialists or general dentists who are referring or peripheral clinicians
- to complete and submit dental claims for third party adjudication
- to comply with legal 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 permit potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver records to dentist's insurance carrier to enable 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 collect unpaid accounts and process credit card payments
- to assist this office to comply with all regulatory requirements and comply generally with the law
- for teaching and demonstrating purposes on an anonymous basis

By signing the Patient Consent Form, you agree to give your informed consent to the collection, use and/or disclosure of your personal information for the purposes 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 (RI-IPA) for the purpose 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. *Should you choose to refuse to give consent for use/disclosure of your personal information, we will explain the ramifications of that decision to you.*

PATIENT CONSENT

I have reviewed the above information regarding how your office will use my personal information, and measures taken to protect my privacy. I agree that Kent Place Dental can collect and disclose personal information about me as set out in the policies stated above.

_____ _____

Signature Date

_____ _____

Print Patient's Name Signature of Witness (staff member)