Aberdeen DENTISTRY

Tel: 905-605-5501
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Patient Information Form

Name: _____ _____
First name Last name

Address: _____ _____ _____ _____ _____
Street Apt/Unit # City Province Postal Code

Date of Birth: ____ /___ /_____ Cell: (_____)_____ Home: (_____)_____ Work : (____)_____
DD MM YYYY Email ID: _____

Referred by: (a) Friend / Family _____ (b) Facebook (c) Flyers (d) Google (e) Radio (f) Other _____

Emergency Contact Name: _____ Cell: (____)_____

Family Doctor: _____ Cell: (____)_____

INSURANCE INFORMATION (If Applicable)

Insurance Company: _____

Employer/Group Policy Holder: _____ Insurance Year End: _____

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

FINANCIAL INFORMATION: This account will be paid by: Cash☐ Cheque☐ Credit Card☐ Insurance☐ Other☐

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

MEDICAL HISTORY:	**Yes**	**No**	
1. Are you presently under the care of a physician?	☐	☐	If yes, explain: _____
2. Have you ever had a serious illness or been hospitalized?	☐	☐	If yes, explain: _____
3. Are you taking any drugs or medication currently?	☐	☐	Drug/s: _____
4. Do you suffer from any allergies? (Hay fever, latex, etc.)	☐	☐	If yes, mention: _____
5. Do you bruise easily or have prolonged bleeding?	☐	☐	
6. Have you ever fainted had shortness of breath or chest pains?	☐	☐	
7. Have you ever been warned against using any medication?	☐	☐	If yes, which? _____
8. Have you taken prolonged medical or non-medical drugs previously?	☐	☐	Specify _____

9. Have you ever had an adverse effect to any of the following: **Aspirin** ☐ **Barbiturates** (sleeping pills)☐ **Codeine** ☐ **Darvon**☐ **Local Anesthetic** ☐
Antibiotics – (Penicillin☐ Sulfonamide☐ Other☐_____)

10. **Women:** Are you pregnant? Yes☐ No☐ Have you reached menopause? Yes☐ No☐ Are you taking birth control? Yes☐ No☐

11. Do you or have you ever had any of the following: **Please ☑appropriate boxes**

☐A.I.D. S	☐Cancer	☐Heart disease/attack	☐Jaundice	☐Rheumatic/Scarlet fever
☐Anemia	☐Circulation problems	☐Heart murmur	☐Kidney disease	☐Sickle cell/disease
☐Angina pectoris	☐Congenital heart lesions	☐Heart pacemaker/surgery	☐Liver disease	☐Sinus Trouble
☐Anorexia nervosa	☐Cortisone/steroid	☐Heart rhythm disorder	☐Leukemia	☐Stomach/intestinal probs.
☐Arthritis/rheumatism	☐Diabetes	☐Hepatitis A/B/C	☐Lung Disease	☐Stroke
☐Artificial heart valve	☐Drug/Alcohol dependence	☐Herpes	☐Malignant hyperthermia	☐Thyroid disease
☐Artificial joints (hip, knee)	☐Emphysema	☐High/Low Blood Press.	☐Mental/nervous disorder	☐Tuberculosis
☐Asthma	☐Epilepsy or seizures	☐H.I. V Positive	☐Mitral valve prolapsed	☐Ulcers
☐Blood Disorders	☐Glandular disorders	☐Hodgkin's disease	☐Organ transplant/implant	☐Venereal disease
☐Bronchitis	☐Glaucoma	☐Hyper (Hypo) Glycemia	☐Psychiatric treatment	☐Other_____
☐Bulimia	☐Head/Neck injuries	☐Hypertension	☐Radiation/Chemo.	☐**None**

12**. Children Only: Have you recently had any of the following (approximate date):** ☐Chicken Pox _____
☐Measles _____ ☐Mumps _____ ☐Strep Throat_____ ☐Tonsillitis _____

DENTAL HISTORY:

1. What is the reason for your visit today? _____

2. When was your last dental visit? _____ Last X-Ray? _____

3. Have you ever had local anesthetic (freezing)? Yes☐ No☐ Any complications? Yes☐ No☐ Please specify: _____

GENERAL RELEASE: I, _____, understand that the information contained in the dental and medical history portion of this chart is important to my treatment. I certify that all the information 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 provider as is required by this dental office. I authorize this dental office to perform diagnostic procedure as may be required to determine necessary treatment. I understand that 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.

_____ _____ _____
Dentist Signature Signature: ☐Patient ☐Parent ☐Guardian Date

P.T.O

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. Inderpreet Singh act 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. The 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 on 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 assist this office, 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 of disclosure of your personal information, and we will explain the ramifications of that decision, and the process. **By signing this consent section of this Patient Consent Form, you have authorized release, to your dental benefits plan administrator and the CDA, information contained in claims submitted electronically. You also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.**

By signing this consent section of this Patient Consent Form, you have authorized to assign your benefits, payable from claims submitted electronically to Dr. Inderpreet Singh and authorize payment directly to them. This authorization shall continue in effect until the undersigned revokes the same.

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 Aberdeen Dentistry can collect, use and disclose personal information about me as set out above in the information about the office's privacy policies.

_____ Date: _____

Signature Patient/Parent/Guardian