611 Wanless Drive, Unit #5
Brampton, Ontario, L7A 3Y6
Phone: (905) 840-6767
Email: office@thesunshinedental.ca

WELCOME TO OUR DENTAL OFFICE

Date: ____________________

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. PLEASE PRINT.

PERSONAL INFORMATION - This information will enable us to maintain communication with you.

The patient is an: Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian: ____________________

Name: (last) (first) (initial) Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Prefers to be called: ____________________

Address: (street) (apt.#) (city) (province) (postal code)

Home Phone: __________ Health Card # / O.H.I.P. #: __________

Bus. Phone: __________ Ext. ______ Employer: __________ May we call you at work? ☐

Cell Phone: __________ Pager No: __________ E-Mail address: __________

Date of Birth: __________ Age: ______ Sex: ______ Marital Status: ______ Name of Spouse: __________

Are other family members patients at our office? Yes ☐ Names: __________

MEDICAL - This information will enable us to make any essential contacts.

Family Physician: __________ Phone: __________

Medical Specialist: __________ Phone: __________
(if presently under care)

In case of emergency, please contact: __________ Phone: __________

Nearest relative not living with you: __________ Phone: __________

FINANCIAL INFORMATION - This information is necessary to process invoices and apply payments.

Person responsible for account: Self ☐ Spouse ☐ Other ☐ **Please complete all information if different than above.**

Name: (last) (first) (initial) Phone: __________

Address: (street) (apt.#) (city) (province) (postal code)

Employed by: __________ Phone: __________

METHOD OF PAYMENT (For office use only) **CASH** ☐ **CHEQUE** ☐ **CREDIT CARD** ☐ **OTHER** ☐

PRIMARY DENTAL INSURANCE

Subscriber's name:		D.O.B.	
Emp./Grp. policy holder:		Ins. yr. end	
Ins. Co.		Tel.	
Grp./Ind. policy No.		Cert. No.	
I.D./S.I.N.		Max. Coverage	

% coverage: Basic Maj. Rest. Ortho. Other Other

SECONDARY DENTAL INSURANCE

Subscriber's name:		D.O.B.	
Emp./Grp. policy holder:		Ins. yr. end	
Ins. Co.		Tel.	
Grp./Ind. policy No.		Cert. No.	
I.D./S.I.N.		Max. Coverage	

% coverage: Basic Maj. Rest. Ortho. Other Other

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Dental History Questionnaire

Name: MR./MISS/MRS./MS./DR.

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.

1. What is the reason for your visit today? Are you currently experiencing any dental problems?

2. Have you been seeing a dentist regularly? If not, why not? ☐ Yes ☐ No

3. Are you nervous during dental visits? ☐ Yes ☐ No ☐ Not Sure/Maybe
4. Have you had a bad experience or complications during dental treatment? ☐ Yes ☐ No ☐ Not Sure/Maybe
5. When was your last dental visit? What was done at that appointment?

6. When did you last have dental x-rays?

7. Have you ever seen a dental specialist? ☐ Yes ☐ No ☐ Not Sure/Maybe
8. How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?

9. Have you been told to take antibiotics before a dental appointment? ☐ Yes ☐ No ☐ Not Sure/Maybe
10. Do you feel that you have bad breath? ☐ Yes ☐ No ☐ Not Sure/Maybe
11. Are you happy with the appearance of your teeth? ☐ Yes ☐ No ☐ Not Sure/Maybe
12. Do you have any problems with your jaw (clicking, limited movement, pain)? ☐ Yes ☐ No ☐ Not Sure/Maybe
13. Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?
    ☐ Yes ☐ No ☐ Not Sure/Maybe

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

Patient/Parent/Guardian Signature: Date:

Dentist Signature: Date:

DENTIST'S NOTES:

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Medical History Questionnaire

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

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.

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain? ☐ Yes ☐ No ☐ Not Sure/Maybe

2. When was your last medical checkup? ______

3. Has there been any change in your general health in the past year? If yes, please explain.
   ☐ Yes ☐ No ☐ Not Sure/Maybe

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them.
   ☐ Yes ☐ No ☐ Not Sure/Maybe

5. Do you have any allergies? If yes, please list them using the categories below: ☐ Yes ☐ No ☐ Not Sure/Maybe

a) medications ______
b) latex/rubber products ______
c) other (e.g. hay fever, seasonal/environmental, foods) ______

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
   ☐ Yes ☐ No ☐ Not Sure/Maybe

7. Do you have or have you ever had asthma? ☐ Yes ☐ No ☐ Not Sure/Maybe

8. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No ☐ Not Sure/Maybe

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9. Do you have or have you 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/Maybe

10. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No ☐ Not Sure/Maybe

11. 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/Maybe

12. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not Sure/Maybe

13. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not Sure/Maybe

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

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

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease
☐ stroke, TIA	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	☐ shortness of breath
☐ heart murmur	☐ cancer	☐ arthritis	☐ drug/alcohol/cannabis use or dependency	☐ osteoporosis medications (e.g. Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

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17. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)?
☐ Yes ☐ No ☐ Not Sure/Maybe

18. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure/Maybe

19. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not Sure/Maybe

20. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
☐ Yes ☐ No ☐ Not Sure/Maybe

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21. Do you identify as a patient with a disability? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure/Maybe

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

Patient/Parent/Guardian Signature: Date:

Dentist Signature: Date:

DENTIST'S NOTES:

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CONSENT FOR DENTAL TREATMENT

Patient Name: ____ Date: _________________________

I hereby authorize Dr. _______________________________________ to perform: ____________________

DENTAL EXAMINATION

DENTAL EMERGENCY EXAMINTATION

TREATMNET PLAN/RESTRORATIVE CONSULTATION

DENTAL TREATMENT

The risks commonly associated with the dental procedure have been satisfactorily explained to me. The treatment may not achieve the desired results.

I further understand that various personnel may assist the doctor in parts of the treatment. I understand that the practice of dentistry is not an exact science and realize that no guarantee of specific results can be or is hereby made by the doctor or by any member of his/her staff. I also realize that unforeseen conditions may arise during this treatment thereby altering the situation and calling for an exercise of the doctor's best professional judgment in selecting procedures in addition to or different from those presently contemplate; in such a case I request that the doctor do whatever is determined to be in my best interest. I acknowledge that the long- term and hereby agree to refrain as much as possible from detrimental activity such as smoking, drinking alcohol, failing to receive adequate nutrition. I further acknowledge that long-term success is dependent upon effective oral hygiene habits practiced at home and by professional follow-up visits scheduled with the doctor.

I consent to the photographic, and/ or radiographic recording of these procedures by the doctor and his/ her associates for scientific and educational purposes. By my signature below, I agree that I have read this form, that I understand its contents or have had them explained to me, that I agree with each of the statements made, that I have been given an opportunity to ask questions about the treatment, and that my questions have been answered to my satisfaction. I further affirm that the risks, benefits, complications, cost of Treatment and payment options have been discussed with prior to treatment.

"I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist, Sunshine Dental Clinic.

____

(Signature): ___________________________

If signing for a minor, the minor’s name is: ____

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THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

As of January 2004, the Government of Canada has initiated the
Personal Information and Electronics Document Act (PIPEDA)
Please help us comply by reading and signing the following form.

Privacy of your personal information is an important part of our office providing with your quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using the disclosing your personal information responsibly. We also try to be an 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.

To help you understand how we are doing that, we have outlined here how our office is using and disclosing the 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 ensure continuous high-quality services.
To assess your health needs.
To provide health care.
To advise you treatment option.
To enable us to contact you.
To establish and maintain communication with you.
To offer and provide treatment, care, and service 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 efficiently follow-up for treatment, care and billing for teaching and demonstrating purposes on an anonymous basis.
To complete and submit dental claim for third party and payment.
To comply with legal and regulatory requirements, including the delivery of patients charts and records Royal College of Dental Surgeons of Ontario in a timely fashion when required according to the provision of the Regulated Health Profession Act.
To permit potential purchases, practice brokers or advisors to evaluate the dental practice.
To allow potential purchases, practice broker 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 access liability and quantify damages, if any to prepare materials for the Health Professions Appeals 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 general with law.

All our Dentists working at this office are Licensed Dentists by RCDSO. The Dentist providing you with Dental treatment is fully responsible for diagnosing your Dental problems/needs and providing you with the best possible treatment and follow up with the Dentist who has provided you with the treatment. You will in no circumstances hold the office or owner of the Dental Practice responsible for any issue.

What if my dentist gives me a discount on certain fees?
It is mandatory to pay co-payment but if your dentist gives you a discount on certain fees, this is very different from waiving a co-payment. Your dentist may do this, but this is very different from waiving a co-payment. If your dentist discounts his/her fee to you by certain percentage, then that discounted fee must be the fee submitted to your insurance company as the whole fee charges for the services rendered. Your dental plan is a valuable benefit and co-payment is mandatory. Before you ask your dentist to waive a co-payment, think about the consequences to you and your dentist.

By signing the consent section of the patient consent form, you have agreed that you have given your consent to the collection, use and/or disclose of your personal information for the purposes that are listed. If the new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Your information may be accesses by regulatory authorities under the terms of the Regulated Health Professions ACT (RHPA) for the purposes of the Royal College of Dental Surgeons of the Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Our office will not underhand conditions supply your insurer with your confidential medial history. In the event this kind of 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 the permission to release such information. We may also advice you if such a release is inappropriate. You may withdraw your consent for use or disclose of your personal information, and we will explain the ramification of that decision, and the process.

I have understood the above information that explains how our office will use my personal information, and the steps your office is taking to protect my information.

I know your office has a Privacy Code, and I can ask to see the code at any time in the office, **SUNSHINE DENTAL CLINIC** acts as the Privacy Information Officer.
I agree that the members of the Dental Team of SUNSHINE can collect, use, and disclose personal information as set out above in the information about the office's privacy policies.

Sign:	Date:
Print Name:	Signature of Witness: