Roseland
FAMILY DENTAL

CONFIDENTIAL PATIENT INFORMATION

☐Mr ☐Mrs ☐Ms ☐Miss ☐Dr Health card#_____

Patient Name:_____ Preferred Name: _____
Last First

Date of Birth: D____/M____/Y____ E-mail: _____

Address: _____Unit #_____ City: _____

Province: _____ Postal Code: _____ Employer:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

We're digital- May we contact you by text message or email? ☐ Yes ☐ No

Gender: ☐Male: ☐Female: ☐Undefined Status (check One) ☐Minor ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Person Responsible for This Account (If different from patient): _____

Primary Insurance Company: _____ **Secondary Insurance Company:** _____

Subscriber's Name: _____ Subscriber's Name:_____

Date Of Birth: D_____/M_____/Y_____ Date Of Birth: D___/M___/Y____

Policy/Plan #:_____ Policy/Plan #: _____

Certificate/ID #: _____ Certificate/ID #: _____

Employer:_____ Employer:_____

Is anyone in your family already a patient in this office? ☐Yes ☐No _____

How did you hear about Roseland Dental? (check all that apply)

☐Google ☐Instagram ☐Facebook ☐Word of mouth (name of person)_____
☐Walk by ☐Community event ☐Other- please specify_____

DENTAL HISTORY

Date of last dental visit:_____ Date of last cleaning:_____Date of last dental x-rays:_____

Do you smoke or use chewing tobacco? ☐Yes ☐ No Do you use cannabis products: ☐Yes ☐ No if so how often?_____

Please check any of the following problems that may apply to you:

☐Sensitivity (hot, cold and/ or sweet) ☐Headaches, earaches or neck pain

☐Tooth pain or discomfort while chewing ☐Grinding or clenching teeth

☐Bleeding teeth or fillings ☐Jaw joint pain (clicking/cracking)

☐Broken teeth or fillings ☐Bad breath or bad taste in your mouth

☐Loose, tipped or shifted teeth ☐Sore spots/ growths

Do you have or have you had the following?

☐Dentures ☐Braces ☐Partial dentures ☐Periodontal disease (gum disease) ☐Difficult extractions

If you could change your smile, you would……..

☐Make your teeth brighter ☐Repair chipped teeth ☐Make your teeth straighter ☐Replace missing teeth

☐Close spaces ☐Replace old crowns that don't match ☐Replace silver fillings with white fillings

☐Have a smile makeover

Name of previous dentist:_____Why did you leave your dentist?_____

What if anything, in the past has kept you from having dental treatment?_____

What is the most important thing to you about your future smile and dental health?_____

MEDICAL HISTORY

Please circle any of the following conditions that you have, or have had in the past:

☐AIDS	**☐Drug addiction**	**☐HIV positive**	**☐Respiratory problems**
☐Allergies, seasonal	**☐Emphysema**	**☐HPV**	**☐Rheumatic fever**
☐Anemia	**☐Excessive bleeding**	**☐Jaundice**	**☐Rheumatism**
☐Arthritis	**☐Fainting**	**☐Jaw joint pain**	**☐Scarlet fever**
☐Artificial heart valve	**☐Glaucoma**	**☐Kidney disease**	**☐Seizures**
☐Artificial joints	**☐Heart conditions**	**☐Liver disease**	**☐Sleep apnea**
☐Asthma	**☐Heart lesions, congenital**	**☐Low blood pressure**	**☐Stomach problems**
☐Blood disease	**☐Heart murmur**	**☐Mitral valve prolapse**	**☐Stroke**
☐Bruise easily	**☐Heart surgery**	**☐Anxiety/depression**	**☐Thyroid disease**
☐Cancer	**☐Hepatitis A**	**☐Pacemaker**	**☐Tuberculosis**
☐Chemotherapy	**☐Hepatitis B**	**☐Phen Fen (1 month +)**	**☐Ulcers**
☐Diabetes	**☐Hepatitis C**	**☐Pregnant currently**	**☐Venereal diseases**
☐Dizziness	**☐High blood pressure**	**☐Radiation**	**☐OTHER:_____**

Women: Are you pregnant or think you may be pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐ No

Please list any medications that you are taking, including non-prescription medications, herbs, vitamins, and oral contraceptives:_____

Pharmacy name:_____ Pharmacy #:_____

Do you have any of the following allergies?

☐Penicillin	**☐Latex**	**☐Sulpha**	**☐Nitrous oxide**
☐Aspirin	**☐Local anaesthetic**	**☐Erythromycin**	**☐Valium**
☐Codeine	**☐Percocet**	**☐Other:_____**	

Patient Signature: _____ **Date**: _____

Dentist Signature:_____ Date:_____

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Privacy Consent Form/Office Cancellation Policy

Privacy of your personal information is an important part of our practice. 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 as clear as possible about the way in which, we handle your personal information.

All our staff members who encounter 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.

The office will collect, use and disclose information about you for the following purposes:

- To assess your health needs and to advise you of treatment options
- To enable us to contact you and maintain communication with you by mail/email/text/telephone/social media
- 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 dentist and/or peripheral dentist
- To allow us to efficiently follow-up for treatment, care and billing
- To complete and submit dental claims for third party adjudication and payment
- To allow 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 practice sale
- To deliver your charts and records to the dentists' insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To invoice for goods and services, process credit card payments and to collect generally with the law
- 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 required, according to the provisions of the Regulated Health Professions Act.

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 **Roseland Family Dental** can collect, use and disclose personal information about

Office cancellation policy: Please initial once read

Roseland Family Dental will require 48 hours/2 business days in order to avoid a cancellation fee. This fee is set by the office and a rate of $50 per hour reserved in our schedule will be charged for any short notice cancellations not deemed an emergency.

Please initial that you have read our cancellation policy_____

Patient Signature: _____

Date: _____

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Financial Agreement

Our mission at Roseland Family Dental is to provide excellence in dentistry that meets your individual needs. In order to reduce the cost of providing dentistry to our clients, payment is expected at the time of service. We offer the following payment methods:

Non-Assignment of benefits with payment in full.

Payment is made in full by cash, interact, Visa or MasterCard with non-assignment of your dental benefits or if you do not have dental coverage. We will process your dental insurance claim for you and have the payment sent directly to you.

Assignment of benefits.

We will accept assignment of your dental benefits and collect to co-payment (difference) at the time of service.

Same day fee for service (No Benefits)

Payment is required the day services are rendered.

PATIENT CERTIFICATION AND CONSENT, I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I will assume full responsibility for the fees associated with these procedures. Unless other arrangements are made, payment is due at each office visit. Unpaid accounts may be subject to interest. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and the dentist. I authorize the dentist to treat me and I assume full responsibility of the fees.

Patient name: _____

Signature: _____

Date: _____