Welcome… It is our pleasure to welcome you to our dental home. Our dental team requires this information to assist in personal and accurate diagnosis and treatment planning. All information is strictly confidential. Our team is available to assist you with the completion of these forms.
PLEASE PRINT.

PERSONAL INFORMATION ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Child ☐ Other

Name: _____ Date of Birth: _____
(Last) (First) (Initial) D M Y

Address: _____
(Street) (Apt. #). (City) (Province) (Postal Code)

Cell: (___)_____ Email: _____ Business:(___)_____

Home: (___)_____ Best contact: _____ Who may we thank for inviting you? _____

IN CASE OF AN EMERGENCY PLEASE NOTIFY:

Name: _____ Phone Number: (___)_____

Responsible Party's Signature: _____ Date: _____
(First) (Last) D M Y

Family Physician Name: _____ Phone Number: (___)_____

DENTAL INSURANCE INFORMATION: ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE:	SECONDARY DENTAL INSURANCE:
Subscriber's Name: _____	Subscriber's Name: _____
Subscriber's Date of Birth: _____	Subscriber's Date of Birth: _____
Address If Different From Above: _____	Address If Different From Above: _____
Employer's Name: _____	Employer's Name: _____
Insurance Company: _____	Insurance Company: _____
Group Number: _____	Group Number: _____
Certificate Number: _____	Certificate Number: _____

FINANCIAL POLICIES

Our practice helps patients to collect their insurance benefits by completing the standard dental form. In all cases, the patient is fully responsible for the complete cost of treatment on the day of their appointment. We accept Visa, American Express, MasterCard, cash and debit card. A 50% deposit is required for all extensive treatment. The balance of the fee is to be paid following the completion of the treatment phase, unless alternative arrangements have been made. For our regular patients who require extensive treatment plans we are happy to set up written payment plans. Emergency patients who are not regular patients of our office, and who have not established a credit rating with us, are expected to pay for services rendered. In the event that an emergency occurs after regular business hours, the fees incurred will include a full emergency exam fee, plus a fee for any treatment performed. We require 2 business days notice to change or cancel all appointments. Failure to do so may result in a $100 service fee. A service charge of $50 will be applied to any returned cheques. Any accounts sent to collections will be charged an administrative fee of $100.

Signature of Account Holder: _____ Date: _____

HEALTH INFORMATION

The following information is required by our clinical dental team to assist in proper diagnosis and treatment planning. All information is strictly confidential. Please check YES or NO to each question. If you are unsure of a question, please contact your dental provider.

		Yes	No
1.	Do you identify as a patient with a disability? If yes, please explain: _____	☐	☐
2.	Are you being treated for any medical condition at present or within the past 2 years? If yes, please explain: _____	☐	☐
3.	Have you been hospitalized or had a serious illness in the last 2 years? If yes, please explain: _____	☐	☐
4.	Has there been any changes in your general health in the past year? If yes, please explain: _____	☐	☐
5.	When was your last medical check up? _____		
6.	Have you recently or are you presently taking any PRESCRIPTION or NON PRESCRIPTION drugs? If yes, please list: _____	☐	☐
7.	Have you ever reacted adversely to any of the following? PLEASE CIRCLE Antibiotics (e.g. Penicillin), Aspirin, Local Anaesthetic ("dental freezing"), Codeine, Nitrous Oxide ("laughing gas"), or other: _____	☐	☐
8.	Do you have any of the following? PLEASE CIRCLE: Asthma, Hay Fever, Food Allergies, Metal or latex Allergies, Skin rashes, hives, or any other allergic condition? _____	☐	☐
9.	Do any of these allergic conditions result in head ache, nausea, swelling, shortness of breath or chest constriction? If yes, please explain: _____	☐	☐
10.	Have you had any injury to or surgery on your face or jaws? If yes, please explain: _____	☐	☐
11.	Do you smoke, or use any other form of tobacco/cannabis/vape? _____ Are you presently using nicotine replacement therapy (patch, gum)? _____	☐	☐
12.	Are you alcohol, cannabis or drug dependent? _____	☐	☐
13.	Women only: Are you pregnant or is there a chance you may be?	☐	☐
	If yes, what is the expected delivery date? _____		
	If no, are you taking birth control medication?	☐	☐
	Are you breastfeeding?	☐	☐

INDICATE WHICH OF THE FOLLOWING YOU HAVE EXPERIENCED:

	Yes	No		Yes	No		Yes	No
Chest Pain	☐	☐	Dizziness	☐	☐	Seizures	☐	☐
Swollen ankles, feet or hands	☐	☐	Ringing in the ears	☐	☐	Excessive thirst	☐	☐
Shortness of breath	☐	☐	Hearing difficulty	☐	☐	Dry mouth	☐	☐
Recent weight loss, fever, night sweats	☐	☐	Ear aches	☐	☐	Difficulty swallowing	☐	☐
Persistent cough, coughing up blood	☐	☐	Severe headaches	☐	☐	Frequent vomiting, nausea	☐	☐
Bleeding problems, bruising easily	☐	☐	Fainting spells	☐	☐	Joint pain/stiffness	☐	☐
Sinus Problems	☐	☐	Blurred vision	☐	☐	Throat infections	☐	☐

INDICATE WHICH OF THE FOLLOWING YOU HAVE OR EVER HAD:

	Yes	No		Yes	No		Yes	No
AIDS or HIV	☐	☐	Heart murmur	☐	☐	Psychiatric treatment	☐	☐
Anaemia	☐	☐	Heart pacemaker	☐	☐	Radiation treatment/Chemotherapy	☐	☐
Angina Pectoris	☐	☐	Heart surgery	☐	☐	Rheumatic/Scarlet fever	☐	☐
Arthritis/Rheumatism	☐	☐	Hepatitis A,B or C	☐	☐	Sickle Cell Disease	☐	☐
Artificial heart valve	☐	☐	Herpes	☐	☐	Sinus trouble	☐	☐
Artificial joints (hip, knee etc)	☐	☐	□High □Low Blood Pressure	☐	☐	Steroid therapy	☐	☐
Blood disorder	☐	☐	Hypo/Hyperglycemia	☐	☐	Stomach/Intestinal problems	☐	☐
Bronchitis	☐	☐	Hypertension	☐	☐	Stroke	☐	☐
Cancer or Tumours	☐	☐	Jaundice	☐	☐	Thyroid/Adrenal Disease	☐	☐
Contact lenses or eye glasses	☐	☐	Kidney or Bladder disease	☐	☐	Transfusions	☐	☐
Diabetes	☐	☐	Liver disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Lung disease	☐	☐	Ulcers	☐	☐
Epilepsy or seizures	☐	☐	Malignant Hyperthermia	☐	☐	Venereal Disease	☐	☐
Fainting or dizzy spells	☐	☐	Mental/Nervous disorder	☐	☐	Family history of Diabetes	☐	☐
Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Family history of Heart Disease	☐	☐
Head/neck injuries	☐	☐	Organ transplant/medical implant	☐	☐	Family history of tumours	☐	☐
Heart disease or heart attack	☐	☐	Osteoporosis	☐	☐			

Are there any conditions or diseases not listed above that you have or have had? Yes☐ No☐

If Yes, please list: _____

DENTAL INFORMATION

		Yes	No
1.	Are you having any dental problems or discomfort with your mouth that needs immediate attention? *If yes, please explain:* _____	☐	☐
2.	When was your last visit to the dentist? _____		
3.	Have you been seeing a dentist regularly?	☐	☐
4.	Have you ever had a bad dental experience or complication? If so, please explain: _____	☐	☐
5.	Do you experience anxiety or nervousness during dental appointments? _____	☐	☐
6.	When was the last time you had Dental x-rays taken? _____		
7.	Do you need antibiotics before dental treatment?	☐	☐
8.	Do you have or have you had any of the following? *Please check those that apply:*	☐	☐
	☐ Periodontal Treatment ☐ Orthodontic Treatment ☐ Night Guard/Bite Plate ☐ Implants ☐ Full Dentures ☐ Partial Dentures ☐ Fixed Bridgework ☐ Crowns		
9.	Are there any growths or sore spots in your mouth?	☐	☐
10.	Do your gums bleed when brushing/flossing or do you suffer pain or swelling of your gums?	☐	☐
11.	Have you noticed any of your teeth are loose or shifting?	☐	☐
12.	Have you lost any teeth or have you had any extractions?	☐	☐
13.	Does food get caught between your teeth?	☐	☐
14.	Are any of your teeth sensitive to hot, cold, sweets or pressure?	☐	☐
15.	How often do you brush your teeth? _____		
16.	Do you use any of the following? *Please check those that apply?*	☐	☐
	☐ Dental Floss ☐ Proxa brush ☐ Stimudents ☐ Mouthwash ☐ Rubbertip stimulator ☐ Waterpik ☐ Electric toothbrush ☐ Tooth picks		
17.	Do you have or have you had an unpleasant taste or odour in your mouth?	☐	☐
18.	Do you experience or have you experienced any of the following? *Please check those that apply.* ☐ Popping, clicking/snapping or pain in your jaw during chewing ☐ Pain in or around your ears or side of the face ☐ Difficulty opening or closing your mouth		
19.	Do you have any of the following habits? *Please check those that apply:*	☐	☐
	☐ Clenching of teeth ☐ Thumb sucking ☐ Chewing on pencils/pens ☐ Grinding of teeth ☐ Mouth breathing ☐ Chewing on fingernails/checks/tongue or lips		
20.	Are you happy with the appearance of your smile? *If no, what would you like to change?* _____	☐	☐

GENERAL RELEASE

I, the undersigned, certify that all the personal, dental and medical information provided in this document is true to the best of my knowledge, and I have not omitted any information. I have had the opportunity to ask questions and receive answers to my questions regarding my dental and medical history. Should there be any change in my health status in the future, I will advise the office. I authorize the clinical team to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that the information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information.

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

Name of Guardian: _____ Please Print

Dentist's Signature: _____ Date: _____

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. Robert vanGalen acts as a 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.

Our 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 service
- to assess your health needs
- 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 of 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 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 collect unpaid accounts
- to assist this office to 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 purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defence of a legal issue.

Our office will not under any condition 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 specific consent. When unusual requests are received, we will contact you for your permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use and disclosure of your personal information, and we will explain the ramifications of that decision, and the process. In addition, information older than 24 months may be stored offsite in a secure location.
Please do not hesitate to discuss our policies with any member of our office staff.

PATIENT CONSENT

I have reviewed the above information that explains how the office will use my personal information, and the steps the office is taking to protect my information. I know that the office has a Privacy Code, and I can ask to see the Code at any time.
I agree that Shelburne Smile Centre Dentistry can collect, use and disclose personal information about _____ as set out above in the information about the office's privacy policies.

Signature: _____ Print Name: _____ Date: _____

Witness Signature: _____ Print Name: _____ Date: _____