

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First M

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐Other \_\_\_\_\_\_\_\_\_\_

Birth Date (DD/MM/YYYY):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (Home):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(cell):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Apartment #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City Province Postal code

Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of emergency, we should notify:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of family doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone or address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of medical specialist (If applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Area of specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone or address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance**

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Birth Date (DD/MM/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance (if applicable)

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Birth Date (DD/MM/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID #\_\_\_\_\_\_\_\_\_\_\_\_

By signing this, I authorize ***Innisfil Dental Arts*** to release any patient record information needed to process benefit claims for me or my dependents and to submit claims on my (or their) behalf related to services I or my dependents have or will receive.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**HEALTH INFORMATION**

**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.**

Date of Last Dental Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for this visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

☐ Allergy- Aspirin ☐ Heart Disease

☐ Allergy- Penicillin ☐ Heart Murmur

☐ Allergy- Latex ☐ Hepatitis

☐ Allergy- Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ High Blood Pressure

☐ AIDS/HIV ☐ Kidney Disease

☐ Anemia ☐ Leukemia

☐ Arthritis ☐ Lung Disease

☐ Artificial Joints ☐ Mental Disorders

☐ Asthma ☐ Mitral valve prolapse

☐ Blood Disease ☐ Nervous Disorders

☐ Cancer/Tumors ☐ Pacemaker

☐ Chemotherapy ☐ Radiation Treatment

☐ Chest pain, angina ☐ Respiratory Problems

☐ Diabetes ☐ Rheumatic Fever

☐ Dizziness ☐ Rheumatism

☐ Drug/alcohol/cannabis use or dependency ☐ Sinus Problems

☐ Epilepsy (Seizures) ☐ Steroid therapy

☐ Excessive Bleeding ☐ Stomach Problems

☐ Fainting ☐ Stomach ulcers

☐ Glaucoma ☐ Stroke

☐ Hay Fever ☐ Thyroid Disease

☐ Head Injuries ☐ Tuberculosis

☐ Heart Attack ☐ Osteoporosis medications

(e.g. Fosamax, Actonel)

1. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.

* Yes ☐ No ☐ Not Sure/Maybe

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. 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



3. When was your last medical checkup? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



4. Has there been any change in your general health in the past year? If yes, Please explain.

* Yes ☐ No ☐ Not Sure/Maybe



5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list

them. ☐ Yes ☐ No ☐ Not sure/Maybe



6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

* Yes ☐ No ☐ Not sure/Maybe



1. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
	* Yes ☐ No ☐ Not Sure/Maybe
2. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)



* Yes ☐ No ☐ Not Sure/Maybe

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

10. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

☐ Yes ☐ No ☐ Not Sure/Maybe

Due Date:



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

Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Updated May, 2020



Thank you for choosing Innisfil Dental Arts to contribute to your dental health needs! To best serve our patients, Innisfil Dental Arts offers extended hours throughout the week as well as weekend appointments to accommodate all of our patient’s busy schedules. Our office hours are as follows:

Monday 10:00am – 5:00pm

Tuesday 10:00am – 5:00pm

Wednesday 10:00am – 5:00pm

Thursday 10:00am – 5:00pm

Friday 10:00am – 4:00pm *\*by appointment only*

Saturdays 10:00am – 3:00pm *\*by appointment only*

To better serve all of our patients, we like them to have a clear understanding not only of their dental treatment but also their financial obligations. If you have any questions about your treatment or its costs, we have dedicated staff available to meet with you at your convenience, free of charge to answer all of your questions. We require all of our patients to leave payment for services rendered on the day of treatment.

Payment options accepted: Visa, Mastercard, Interac,. E-transfer. **We do not accept cheques.**

If you require any other arrangements, please discuss them with us **PRIOR** to receiving your dental treatment.

**CONSENT**

The undersigned hereby authorizes the Dentist and any staff authorized by the Dentist to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of your dental situation. I also authorize the Dentist to perform any and all forms of treatment and therapy, and to prescribe medications, that may be indicated as mutually agreed upon in advance. I understand that during a procedure circumstances may dictate a change in technique or additional fees which I am responsible for.

I also understand the use of anaesthetic agents embodies a certain risk: including but not limited to the possibility of discomfort, bleeding, allergic reactions, prolonged numbness, infection, tenderness and increased heart rate.

I understand that my dental insurance is a contract between me and my insurance carrier, and not between the insurance carrier and the Dentist, and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered. I further understand that a late charge will be added to any overdue balance.

I will provide two full business days’ notice if I need to cancel or change an appointment that was reserved for me, otherwise a charge will apply. For appointments greater than one and a half hours, I will provide three full business days’ notice or a higher cancellation fee will apply.

Innisfil Dental Arts understands that the goal of anti-spam legislation in Canada is to deter damaging and misleading forms of spam. ADPC ensures that network security programs, spam filters and anti-virus software is utilized at all times on all company computers and related technologies.

In order to achieve the goals of the anti-spam legislation, Innisfil Dental Arts will act in compliance with CASL. In order to ensure compliance, Innisfil Dental Arts must gain your consents in order for us to communicate with you by electric means (e-mail & text messaging) prior to such communications. As we are a modern office with a focus on being as paper free as possible, then it is understood that we must be able to communicate with you by modern communication methods, which include telephone, e-mail, text messaging and mail. We contact our patients to schedule and confirm appointments, inform them about our office and generally to carry on the business of taking care of your dental health. Therefore it is understood that by becoming a patient you consent to such communications. Please let us know your preferred method of communication.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 **Signature of Patient Date Presented By**



**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 the 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 very important to us to provide this service to our patients.

In this office, Dr. J. Lee is 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 protections of your information.

Attached to this consent form, we have outlined that 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 will receive the best quality dental care.

**How Our Office Collects, Uses and Disclose 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.

This 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 RCDSO 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 RCDSO, 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 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 the purposes of the RCDSO fulfilling its mandate under the RHPA, and for the defense of legal issues.

Our office will not under any conditions supply your insurer with your confidential medical 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 permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for us or disclosure of your personal information, and we will explain the ramifications of that decision and the process.

**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 hereby acknowledge that the courts if the Province of Ontario in accordance with the laws of Canada shall have exclusive jurisdiction to hear any complaint, demand, proceeding or cause of action whatsoever.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Dr. Jaemin Lee and any or all staff at Innisfil Dental Arts can collect, use and disclose personal information only as set out above in the information about the office’s privacy policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date Signature of Witness



**COVID – 19 Screening**

**Patients Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date and Time:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you have a fever and or new onset of cough or difficulty breathing?**

**Yes or No**

1. **Have you travelled outside of Canada in the past 14 days?**

**Yes or No**

1. **Have you had any close contact with a probable or confirmed case of COVID-19?**

**Yes or No**

1. **Any close contact with a person who has a fever, new onset cough, difficulty breathing or who has travelled outside of Canada within the last 14 days?**

**Yes or No**