WELCOME TO NASH DENTAL

1656 NASH ROAD, #4. COURTICE, ON L1E 2Y4.
PH: 289.600.NASH(6274). FAX: 289.274.9052

PATIENT INFORMATION

A PARENT OR GUARDIAN WILL BE RESPONSIBLE FOR DECISIONS ON MY TREATMENT: YES _____ NO_____

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

____

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

ADDRESS (HOME):________________________________

____

PHONE (HOME): ________________________________

PHONE (ALTERNATE): ____________________________

EMAIL: _______________________________________

PREFERRED CONTACT: ☐ TEXT ☐ EMAIL ☐ PHONE

OCCUPATION: __________________________________

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:_________________________________

RELATIONSHIP:____________________________

PHONE: __________________________________

NAME OF FAMILY DOCTOR: _________________

PHONE:__________________________________

PREVIOUS DENTIST_________________________

PHONE:__________________________________

HOW DID YOU HEAR ABOUT US?

____

Consent to Receive Email

☐ I agree to receive emails/texts containing appointment reminders, news, and promotions from Nash Dental

FINANCIAL INFORMATION

PERSON RESPONSIBLE FOR FINANCIAL MATTERS: SELF SPOUSE PARENT/GUARDIAN

IF DIFFERENT FROM ABOVE INFORMATION:

NAME: ___________________________________

ADDRESS:_________________________________

____

PHONE:___________________________

DATE OF BIRTH (DAY/MONTH/YEAR):

____

PRIMARY INSURANCE:

INSURANCE COMPANY: ______________________

EMPLOYER:________________________________

POLICY #:_________________________________

GROUP/ID #: ______________________________

SECONDARY INSURANCE:

INSURANCE COMPANY: ______________________

EMPLOYER:________________________________

POLICY #:_________________________________

GROUP/ID #: ______________________________

(Please continue on to Medical and Dental History – Thank you)

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. Thank-you!

MEDICAL HISTORY:

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?
____ YES NO

2. When was your last medical check-up? ____

3. Has there been any change in your general health in the past year? If yes, please explain. YES NO

____

4. Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? YES NO

If yes, please list: ____

5. Do you have any allergies? If yes, please list using the categories below: YES NO

A. Medications: ____

B. Latex/ rubber products: ____

C. Others: Seasonal, Food, etc: ____

6. Have you ever had a peculiar or adverse reaction to any medications or injections? YES NO

If yes, please explain:____

7. Have you ever been hospitalized for any illness/operations? YES NO

If yes, please explain: ____

8. 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

Please explain: ____

9. Do you have a prosthetic or artificial joint? ____ YES NO

10. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ____ YES NO

11. Do you have/or had hepatitis (A, B, or C), jaundice or liver disease? ______________________ ____ YES NO

12. **Do you have or have you ever had any of the following. Please circle ALL that apply.**

Asthma	Shortness of Breath	Heart Murmur	Stomach Ulcers
Bleeding Disorder	Pacemaker	Rheumatic Fever	Arthritis
Blood Pressure	Cancer	Mitral Valve Prolapse	Seizures (epilepsy)
Chest pain/Angina	Steroid Therapy	Lung Disease	Drug/Alcohol Dependency
Heart Attack	Diabetes	Kidney Disease	Osteoporosis
Stroke	Tuberculosis	Thyroid Disease	Other (Specify) ____________

(Please continue on to next page – Thank you)

13. Do you smoke or chew tobacco products ? YES NO How much? ______________________________________

14. Are you nervous during dental treatment? YES NO ____

15. Any family history of any medical problems? YES NO ____

16. **For Women Only:** Are you breast-feeding or pregnant? If pregnant, when is the expected due date? ______________

DENTAL HISTORY

1. What is the reason for today's visit? ____
2. How frequently do you see a dentist? 3-6 months/Annually/Other____
3. When was your last dental visit? Reason for your last visit? ____
4. How often do you brush your teeth per day? _________ Floss? _________Mouthwash?_____________
5. Are your teeth sensitive to: Cold_____ Heat______ Sweet ______ Other ______
6. Do your gums bleed when: Brush_____ Floss______ Never ______
7. Do your gums feel tender or swollen? ____ YES NO
8. Do you experience bad taste or bad breath in your mouth? _________________________ YES NO
9. Do your jaws pop, click, or lock when you open wide? ______________________________ YES NO
10. Do you grind or clench your teeth? ____ YES NO
11. Does food catch between your teeth? ____ YES NO
12. Have you ever had local anesthesia (Freezing/Numbing)? __________________________ YES NO

    Did you experience any complications? Please specify: ____

13. Have you had any problems with previous dental treatment? _________________________ YES NO
14. Have you had any of the following? Please circle all that apply: Crown, Bridge, Dentures (Full/Partial), Extraction, Orthodontic (Braces), Periodontal (Gum Therapy), Root Canal.
15. On a scale of 1-10 (1= very unsatisfied and 10 = very satisfied), how would you **rate your smile**? Please explain.

____

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information that I have completed is correct and that I have not knowingly omitted any data. I consent to the release of medical information from my medical doctor or other healthcare provider as is required by this dental office. I authorize this dental office to perform any diagnostic procedures required to determine the necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility to fees associated with my dental treatment or diagnostic procedures.

____

Signature Print name Date

(Please continue on to next page – Thank you)

PATIENT CONSENT FORM: COLLECTION, USE AND DISCLOSURE

OF PERSONAL HEALTH INFORMATION

Privacy of your personal health information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients.

In this office, **Dr. Anoli Pabari** is the contact person for personal health information related matters. All staff members who come in contact with your personal health 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 health 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.

How Our Office Collects, Uses and Discloses Patients' Personal Health Information

Our office understands the importance of protecting your personal health 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 personal health 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/confirm appointments.
- to allow us to efficiently follow-up for treatment, care and billing

(Please continue on to next page – Thank you)

- 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 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 health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.

Your personal health 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. You may withdraw your consent for use or disclosure of your personal health information at any time.

Patient Consent

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

I agree that Nash Dental can collect, use, disclose personal health information about __________________________________ (Print Patient Name) as set out above in the information about office's private policies.

____

Signature Print Name Date