Orion Dental

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oriondental.ca

# Welcome to Orion Dental

Fill in this form on your computer (save a copy, then print it) or print it and complete it in pen. Sign each signature line by hand and bring all pages to your first visit. To protect your privacy, please do not email this form.

LAST NAME

FIRST NAME

☐ Male ☐ Female

D.O.B (DD/MM/YEAR)

NICKNAME

ADDRESS

CITY

POSTAL CODE

☐ F/T student

NAME OF SCHOOL

HOME TEL

WORK TEL

CELL

EMAIL

(MOTHER) OCCUPATION (IF CHILD)

(FATHER) OCCUPATION (IF CHILD)

WHO MAY WE THANK FOR REFERRING YOU?

## In case of an emergency, we should notify

NAME

RELATIONSHIP

DAY-TIME PHONE

## Dental insurance

### PRIMARY DENTAL INSURANCE

NAME OF INSURED

INSURED'S DATE OF BIRTH

EMPLOYER

INSURANCE COMPANY

GROUP/POLICY NO.

ID/CERTIFICATE NO.

### SECONDARY DENTAL INSURANCE

NAME OF INSURED

INSURED'S DATE OF BIRTH

EMPLOYER

INSURANCE COMPANY

GROUP/POLICY NO.

ID/CERTIFICATE NO.

## Medical & Dental History

Please take a moment to let us know about your medical and dental history so we are enabled to serve you more effectively and in a way that watches out for your overall health. All information is kept confidential and is protected by doctor-patient confidentiality. The dentist will explain any that you do not understand.

**1) Please mark to indicate if you have you ever had any of the following:**

- ☐ Abnormal bleeding/bruising
- ☐ Anemia/shortness of breath
- ☐ Arthritis/joint/muscle problems
- ☐ Angina/heart problems/heart murmur
- ☐ Cancer
- ☐ Epilepsy/convulsions
- ☐ Heart disease/high blood pressure
- ☐ Fainting
- ☐ HIV/AIDS
- ☐ Allergies (please specify) _____
- ☐ Lung disease/asthma
- ☐ Mental/nervous disorders
- ☐ Rheumatic/scarlet fever
- ☐ Hepatitis A/B/C
- ☐ Diabetes
- ☐ Stroke
- ☐ Developmental disorders
- ☐ Thyroid disease
- ☐ Liver/kidney disease
- ☐ Other _____

2) Do you smoke? ☐ Yes ☐ No

3) Do you use recreational drugs? ☐ Yes ☐ No

4) Are you taking prescription drugs? ☐ Yes ☐ No

SPECIFY _____

5) Are you under any medical care at the present time? ☐ Yes ☐ No

SPECIFY _____

6) Have you ever been in the hospital? (In the past 5 years) ☐ Yes ☐ No

SPECIFY _____

7) Have you ever had any serious illnesses? ☐ Yes ☐ No

SPECIFY _____

8) WHEN WAS YOUR LAST VISIT TO A PHYSICIAN? _____

PHYSICIAN'S NAME _____ TELE _____

9) WHEN WAS YOUR LAST VISIT TO A DENTIST? _____

10) How frequently do you brush your teeth?

☐ 3(+) a day ☐ twice a day ☐ once a day ☐ weekly ☐ seldom

**11) Please mark to indicate "Yes" in response:**

- ☐ Do your gums bleed when you brush/floss?
- ☐ Are any of your teeth causing pain?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Do you grind your teeth? (consciously or during sleep)
- ☐ Do you currently have any dental implants, dentures or partials?

**12) For women only: Are you pregnant or breastfeeding?** ☐ Yes ☐ No

IF PREGNANT, WHAT IS THE EXPECTED DELIVERY DATE? _____

SIGNATURE _____ DATE _____ NAME _____

## Consent for Treatment

I, certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge and I have not omitted data. I consent to the release of medical information from my medical doctor as is required by this dental office. I have had my treatment explained to me and I hereby authorize my dentist to provide the dental treatment I require. This includes the taking of x-rays and the administration of necessary anesthetics and medications.

SIGNATURE

DATE

## Consent for Services

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends on reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed unless other arrangements have been made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can be only extended for a period of six months from the date of the patient examination unless arrangements have been made and authorized by the doctor.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, unless other arrangements have been made and authorized by the doctor.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian:

SIGNATURE

DATE

## Patient Consent Form: for Collection, Use and Disclosure of Personal Information

Protecting the privacy of your personal information is an important part of caring for you. 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. Fahimay Naqvi acts as 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 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 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 everyone on our team is committed to caring for you with respect and protecting your privacy.

## How Our Office Collects, Uses and Discloses 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 review and improve the care and service we provide
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact 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 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 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 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 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

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 Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event of 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 use or disclosure of your personal information and we will explain the ramifications of that decision and the process.

## Patient Consent

I have read 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 **Fahimay Naqvi Dentistry Professional Corporation** can collect, use and disclose my personal information about _____ as set out above in the information about the office's privacy policies.

SIGNATURE

PRINT NAME

DATE

WITNESS SIGNATURE