Welcome to Thornhill Smiles Dental

In an effort to serve you better, we ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

Name: First: _____ Last: _____

Nickname: _____ Date of Birth: _____/_____/_____

Address: Street: _____ Apt: _____

City: _____ Province: _____ Postal Code: _____

Phone: Cell: _____ Home: _____ Work: _____

E-Mail: _____

Emergency Contact: Name: _____ Number: _____

Relationship: _____

Family Doctor: _____ Number: _____

How did you hear about us? _____

Financial Information

Person responsible for financial matters: Self ___ Spouse ___ Parent/Guardian ___ Other ___

Primary Insurance: Policy Holders Name: _____

Insurance Company: _____

Policy/Group # _____ Certificate# _____

Policyholders Date of Birth _____/_____/_____

Secondary Insurance: Policy Holders Name: _____

Insurance Company: _____

Policy/Group # _____Certificate# _____

Policyholders Date of Birth _____/_____/_____

By signing below, I acknowledge the following:
I understand that dental insurance may cover 0-100% of my work. I understand that the dentist(s) and staff are willing to assist me in recovering my dental insurance entitlements. I understand that dental insurance is a contract between me, the insured, and the insurance carrier, not between the insurance carrier and the dentist, and that I am ultimately responsible for all payments for any dental care.
Many carriers now accept EDI (Electronic Data Interchange) submissions, as this will speed the return of insurance cheques (within 3-6 business days). I also authorize EDI submission of my claims.
Furthermore, I acknowledge that appointments are reserved exclusively for me, and that Thornhill Smiles Dental requires 48hrs notice for cancellations, or else there may be a charge. All attempts will be made to remind me of my appointment in advance, however, I understand that it is my responsibility to keep my appointment.

_____ _____

Signature or Patient/Parent/Guardian **Date**

390 Steeles Ave W. #205, Thornhill, ON L4J 6X2 Tel: 905.707.6477 Fax: 905.707.9165
Email: contact@thornhillsmiles.ca

Dental History

Are you currently experiencing any problem in the oral cavity or outside? _____

_____

When was your last dental check-up? _____ Cleaning? _____ Radiographs (x-rays)? _____

How many times a day do you brush? _____ Floss? _____

Have you ever been advised to take antibiotics before dental treatment? _____

Please Answer as Many Questions as You Can

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) #_____ (___)

Have you ever had complications from past dental treatment? _____Y N

Have you ever had trouble getting numb or had any reactions to local anesthetic? _____Y N

Do your gums bleed or are they painful when brushing or flossing? _____Y N

Have you ever been treated for gum disease or been told you have bone loss around your teeth? _____ Y N

Have you ever experienced gum recession? _____Y N

Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____Y N

Have you had any cavities in the last 3 years? _____Y N

Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?____Y N

Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? _____Y N

Are your teeth sensitive to hot, cold, sweets, biting, or to brushing? _____Y N

Have you ever broken or chipped teeth, or had a toothache or cracked filling? _____Y N

Do you frequently get food stuck between any teeth? _____Y N

Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____Y N

Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____Y N

Do you avoid or have difficulty chewing gum, carrots, nuts, bagels or other hard, dry foods? _____Y N

Are your teeth becoming more crowded or developing more spaces? _____Y N

Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____Y N

Do you clench or grind your teeth at nighttime or during the day? _____Y N

Do you have any problems with sleep (i.e., restlessness), waking up with a headache or an awareness of your teeth? _Y N

Do you wear or have you ever worn a bite appliance? _____Y N

Is there anything about the appearance of your teeth that you would like to change? _____Y N

Have you ever whitened (bleached) your teeth? _____Y N

Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____Y N

Have you been disappointed with the appearance of previous dental work? _____Y N

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THORNHILLSMILES DENTAL

Medical History

1. Are you presently under the care of a physician? Y N
   Condition being treated: _____
2. List of ALL medications, supplements and or vitamins: _____
   _____
   _____
3. Have you ever had a serious illness requiring hospitalization or extensive medical care? Y N
   Please specify: _____
4. Have you ever fainted, had shortness of breath or chest pains? Y N Which?_____
5. Have you had any heart problems, cardiac stent placement within the last six months? Y N
6. Do you have or have you ever had any of the following?

Y N Aids/HIV
Y N Anemia or Other Blood Disorder
Y N Angina Pectoris
Y N Anorexia Nervosa
Y N Antidepressant Medications
Y N Any Lumps/Swelling in the Mouth
Y N Artificial Heart Valve/Repaired Heart Defect
Y N Arthritis/Rheumatism
Y N Artificial Joints (orthopedic joints, hips/knees)
Y N Asthma
Y N Autoimmune Disease (lupus, scleroderma)
Y N Blood Disorders
Y N Breathing or Sleep Disorders (sleep apnea, snoring, sinu
Y N Bronchitis
Y N Bulimia
Y N Cancer
Y N Chemotherapy, Immunosuppressive Medication
Y N Circulation Problems
Y N Congenital heart lesions
Y N Contact Lenses
Y N Cortisone/Steroids
Y N Diabetes (type___)
Y N Digestive Disorders (celiac disease, gastric reflux)
Y N Emotional Difficulties
Y N Drug/Alcohol Dependence
Y N Emphysema, Shortness of Breath, Sarcoidosis
Y N Epilepsy, convulsions (seizures)
Y N Gastrointestinal Disorders
Y N Glandular Disorders
Y N Glaucoma
Y N Head/Neck Injuries
Y N Hearing Difficulties/Earache
Y N Heart Disease/Attack
Y N Heart Murmur
Y N Heart Rhythm Disorder
Y N Hepatitis (type____)
Y N High Cholesterol or taking Statin Drugs
Y N Hives, skin rash, hay fever
Y N High/Low Blood Pressure
Y N History of Infective Endocarditis
Y N Hodgkin Disease
Y N Hormone Deficiency
Y N Hyper/Hypo Glycemia
Y N Hypertension
Y N Jaundice
Y N Kidney Disease
Y N Laser Eye Surgery
Y N Liver Disease
Y N Leukemia
Y N Lung Disease
Y N Lupus
Y N Malignant Hyper/Hypothermia
Y N Mental/Health Disorder
Y N Mitral Valve Prolapse
Y N Neurologic Disorders (ADD/ADHD, prion disease)
Y N Organ Transplant/Implant
Y N Osteoporosis/Osteopenia (taking bisphosphonates)
Y N Pacemaker or Implantable Device
Y N Prolonged Bleeding due to a slight cut (INR>3.5)
Y N Psychiatric Disorders/Treatment
Y N Radiation Therapy
Y N Recreational Drug Use
Y N Rheumatic/Scarlet Fever
Y N Sickle Cell Disease
Y N Sinus Trouble
Y N Snoring or Sleep Apnea
Y N Stomach/Intestinal Problems
Y N Stroke (taking blood thinners)
Y N Thyroid/Parathyroid Disease, Calcium Deficiency
Y N Tuberculosis/Measles/Chicken Pox
Y N Tumor/Abnormal Growth
Y N Ulcers
Y N Venereal Disease (Herpes/STD/STI/HPV)
Y N Viral Infections (cold sores/cankers)

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7. Are there any conditions not listed above that you presently have or ever had? Y N
   Which:_____

8. Do you suffer from allergies or have had an allergic reaction to anything? Y N
   - Y N Antibiotics _____
   - Y N Aspirin, Ibuprofen, Acetaminophen, Codeine
   - Y N Latex
   - Y N Local Anesthetic
   - Y N Metals (nickel, gold, silver, other) _____
   - Y N Sulfa
   - Y N Other _____

9. Have you ever been warned against using any other medications? Y N
   Which? _____

10. Do you Smoke? Y N How many per day? _____

11. Is there anything else you would like to discuss with your dentist?
    _____

I certify that to the best of my knowledge the dental and medical history is accurate. I understand that omission of any information can affect my dental treatment.

Signature of Patient/Parent/Guardian: _____ Date: _____

I give the dentist(s) the right to use any x-rays, intra-oral photos, or other data associated with my oral cavity for educational, diagnostic, and promotional reasons.

Signature of Patient/Parent/Guardian: _____ Date: _____

Reviewed by Dr. _____

Signature _____ Date: _____

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Collection, Use and Disclosure of Patient Personal Information

Thornhill Smiles Dental understands the importance of protecting your personal information. To help you understand how we do this, we have outlined how our office is using and disclosing your information. In this office, Dr. David Goldberg acts as the Privacy Information Officer. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be 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.

Thornhill Smiles 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 provide health care
- To advise you of treatment options
- To enable us to contact you
- To allow us to and maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- To offer and provide treatment, care and services in relationship to the oral 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 efficiently follow-up for treatment, care and billing and for teaching and demonstrating purposes on an anonymous basis
- To complete and submit dental claims for third party adjudication and payment
- To comply with the 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 delivery 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

All staff members who come into 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 use and protection of your information.

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 disclose 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 that 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 is 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 reviewed the above information that explains how Thornhill Smiles Dental 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 Thornhill Smiles Dental can collect, use and disclose personal information about the patient noted below and as set out above in the information about the office's privacy policies. Please be assured that every staff person in our office is committed to ensuring that you receive the most complete oral diagnosis and the best quality dental care.

Patient/Guardian Signature _____ **Patient/ Guardian Print Name** _____

Date _____ **Witness Signature** _____

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48 Hour Cancellation Policy

At Thornhill Smiles Dental we strive to render excellent dental care to all of our patients. When an appointment is scheduled, that time has been set aside for you. If that time is missed, it cannot be used to treat another patient.

Our policy is as follows: We require that you give our office at least **48 hours notice** in the event that you need to reschedule or cancel your appointment. This allows for other patients to be scheduled into that appointment slot.

If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$75.00** will be charged to you; this fee cannot be billed to your insurance company and **will be your direct responsibility.**

No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than **20 minutes late** without prior notice for a scheduled appointment, we will consider this a missed appointment and the **$75.00** cancellation fee will be charged. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your understanding.

_____ _____

Patient/Guardian Signature **Patient/ Guardian Print Name**

_____ _____

Date **Witness Signature**

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