
Patient ID#

Medical Alert

# WELCOME

**Help us to get to**
**KNOW YOU BETTER**

Name _____ Mr. Mrs. Miss Ms. Dr.

Telephone # (Home) _____ (Cell) _____ Email: _____

Address _____ Street Box #_____ Town _____ Postal Code _____

Date of Birth ____/____/_____ (DD/MM/YYYY) Emergency Contact Person_____

Whom may we thank for referring you to our clinic? _____

Occupation _____ Employer_____

Business Address_____ Work #_____

Do you have Dental Insurance? _____ Name of Insurance Company _____

Group/Plan # _____ Policy/Certificate #_____

Spouse's Name _____ Date of Birth _____/_____/_____ (DD/MM/YYYY)

Employer _____ Work #_____

Does Spouse have Dental Insurance? _____ Name of Insurance Company _____

Group/Plan # _____ Policy/Certificate #_____

Name of family member responsible for your account_____

## OFFICE POLICY

Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require two business days' notice.

Our policy is that services are paid for at each visit, as they are performed. You are responsible for fee's not covered under your plan. We accept all methods of payment including: VISA, MC, AMEX, debit, cash cheque.

Date _____ Signature _____

## Patient Privacy Consent Form

Our office understands the importance of protecting your personal information. This office will collect, use and disclose information about you for the following purposes:

- To assist your health needs, and advise you of treatment options.
- To provide safe and efficient patient care, and identify and ensure high quality service.
- To allow us to efficiently follow-up for treatment, care and billing.
- To enable us to contact and maintain communication with you to schedule and confirm appointments and to distribute health-care information.
- To communicate with other treating health-care providers, including other dentists.
- To offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally.
- To complete and submit dental claims for third party adjudication and payment.
- To comply with all legal and regulatory requirements.
- To deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, as necessary.
- To permit potential purchasers, practice brokers or advisors to evaluate the dental practice and/or conduct and audit in preparation for a practice sale.
- To invoice for goods and services, process credit card payments, and collect unpaid accounts.

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 about. 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 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 defense of a legal issue.

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 comment.

When unusual requests are received, we will contact you for permission to release such information. 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 this office will use my personal information, and the steps they are taking to protect my information. I know that this office has a Privacy Code, and I may ask to see the Code at any time. Dr. Dimitar Bakalov is the Privacy Information Officer In this office.

I agree that Dr. Bakalov Family Dentistry may collect, use, and disclose personal information as set out above in the information about the office's privacy policies.

Print Name _____

Signature/ Parent/ Guardian _____ Date _____

## MEDICAL HISTORY

Patient Name _____ Nickname_____ Age_____

Name of Physician _____ Phone # _____

Most recent physical examination _____ Purpose_____

What is your estimate of your general Health? **Excellent, Good, Fair, Poor**

### HAVE YOU EVER HAD THE FOLLOWING? Please ✓ (check) appropriate boxes.

Allergic reaction to

- ☐ Aspirin, ibuprofen, acetaminophen
- ☐ Penicillin, erythromycin, tetracycline
- ☐ Codeine
- ☐ Local anesthetic
- ☐ Food allergy _____
- ☐ Latex
- ☐ Metals (gold, stainless steel)
- ☐ Any other medications _____

- ☐ Heart surgery _____
- ☐ Heart murmur
- ☐ Angina pectoris
- ☐ Rheumatic fever / scarlet fever
- ☐ Pacemaker / heart rhythm disorder
- ☐ High blood pressure/ hypertension
- ☐ Low blood pressure / hypotension
- ☐ Stroke _____
- ☐ Heart attack _____
- ☐ Mitral valve prolapse
- ☐ Artificial prosthesis (i.e. heart valve or joints)
- ☐ (knee or hip) _____
- ☐ Anemia or other blood disorder
- ☐ Leukemia
- ☐ Prolonged bleeding due to a slight cut
- ☐ Emphysema
- ☐ Lung disease
- ☐ Asthma

- ☐ Sinus problems
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Hepatitis, type A, B or C
- ☐ Jaundice
- ☐ Malignant hyperthermia
- ☐ Thyroid or parathyroid disease
- ☐ Hormone deficiency
- ☐ Diabetes – type I or II
- ☐ Stomach/intestinal problems
- ☐ Bulimia/ anorexia nervosa
- ☐ Tuberculosis
- ☐ Arthritis/rheumatism
- ☐ Glaucoma
- ☐ Head and neck injury
- ☐ Epilepsy, convulsions (seizures)
- ☐ Viral infections and cold sores
- ☐ Venereal disease
- ☐ HIV / AIDS
- ☐ Immunosuppressant disorder
- ☐ Cancer _____
- ☐ Radiation _____
- ☐ Chemotherapy _____
- ☐ Emotional problems
- ☐ Psychiatric treatment
- ☐ Drug / alcohol dependence
- ☐ Hospitalisation for illness or injury

### ARE YOU:

- ☐ Presently being treated for any other illness
- ☐ Taking medication for osteoporosis/osteopenia

☐ Often exhausted or fatigued
☐ Do you smoke? How much per day? _____
☐ FEMALE – taking birth control pill
☐ FEMALE – pregnant Due date? _____

List any mediations, supplements, and or vitamins taken

Drug _____ Purpose _____
Drug _____ Purpose_____
Drug _____ Purpose_____
Drug _____ Purpose _____
Drug _____ Purpose_____
Drug _____ Purpose_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's or guardian's signature _____
Date _____

## DENTAL HISTORY

How would you rate the condition of your mouth? **Excellent, Good, Fair, Poor**
Previous dentist _____
When was your last dental visit? _____ Last X-ray? _____
How often do you brush? _____ per day Floss? _____ Use anti-bacterial rinse? _____
Have you ever had any of the following? Bridgework, crowns or caps, full or partial dentures, orthodontic (braces), periodontal (gums) or root canal?

**WHAT IS YOUR IMMEDIATE CONCERN? _____**

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:
Have you ever had complications from past dental treatments? Yes or No
Are your teeth sensitive to cold, hot, biting or sweets? Yes or No
Do your gums bleed when brushing, flossing or eating? Yes or No
Do your gums feel swollen or tender? Yes or No
Do you have bad breath or a bad taste in your mouth? Yes or No
Do your jaws crack, pop or grate when you open widely? Yes or No
Do you grind or clench your teeth? Yes or No
Do you have food catch between your teeth? Yes or No
**Have you ever had trouble getting numb or reactions to local anesthetic (freezing)? Yes or NO**

Doctor's signature _____ Date_____