71-D James Street,
Elora, Ontario
N0B 1S0
(519) 846-5331
contact@centrewellingtondental.com

***Welcome to Centre Wellington Dental!***

We appreciate the trust you have placed in us, and we will strive to provide the high quality of dental care that you expect.

The focus of our practice is health-centered, preventative dentistry. We enjoy helping people actively participate in their own health care and control the causes of dental disease. Further, we emphasize aesthetic, adult restorative treatment designed for long-term beauty, comfort, function, and low maintenance.

Our team is devoted to making your appointments as pleasant and enjoyable as possible. We take great pride in our ability to provide you with optimal dental care designed for your unique needs and desires.

The first step toward complete oral health is thorough examination and diagnosis. We want our patients to make informed choices by fully understanding any problems. Our Dentists will review your dental needs with you at this appointment or at a second appointment to provide treatment consultation.

We look forward to meeting you! Your first appointment will be approximately 90 minutes. In order that we may respond to your unique needs and concerns, please complete the enclosed Medical History form, Patient Consent, Health Screening questionnaire and **return them prior to your appointment**. Feel free to ask questions of our Team members. We are all here to help you!

Please keep in mind that we require 24 hours to change or cancel an appointment. A fee of $50.00 will be implemented on appointments cancelled without 24 hours' notice.

Sincerely,

Dr. Kirk Tofflemire
Dr. Danielle Walker
Dr. Emily Israel
Dr. Shruti Patel
Dr. Anish Nanda
Dr. Alvina Siu
Dr. Sarah Mediouni

## *NEW PATIENT FORM*

### Patient Information

First Name: _____ MI: ____ Last: _____ Preferred Name: _____

Date of Birth: _____ Sex: _____ Pronouns: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

### Contact Information

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

How do you prefer to be contacted: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐ Work Phone

Emergency Contact: _____ Relationship: _____ Phone: _____

Name of Physician: _____ Physician's Phone: _____

Pharmacy: _____ Pharmacy's Phone: _____

**PRIMARY BENEFIT INFORMATION**

POLICY HOLDER: _____ DOB: _____

INSURANCE COMPANY: _____ EMPLOYER: _____

PLAN/POLICY NUMBER: _____ I.D./CERTIFICATE NUMBER: _____

**SECONDARY BENEFIT INFORMATION**

POLICY HOLDER: _____ DOB: _____

INSURANCE COMPANY: _____ EMPLOYER: _____

PLAN/POLICY NUMBER: _____ I.D./CERTIFICATE NUMBER: _____

How did you hear about our office? ☐ Google ☐ Website ☐ Facebook ☐ Patient ☐ Other: _____

### Patient Health History

Do you have a history of:

- ○ A.I.D.S/HIV Positive
- ○ Alcoholism
- ○ Anemia
- ○ Arthritis
- ○ Asthma
- ○ Blood Disease
- ○ Bone Disease
- ○ Cancer
- ○ Chest Pain
- ○ Circulatory Problems
- ○ Diabetes Type(s):_____
- ○ Drug Addiction
- ○ Excessive Bleeding
- ○ Epilepsy
- ○ Glaucoma
- ○ Hay Fever
- ○ Head Injuries
- ○ Hearing Impaired
- ○ Heart Disease
- ○ Heart Valve, Murmur
- ○ Hepatitis/Liver Disease Type(s): _____
- ○ Hepatitis Carrier
- ○ High Blood Pressure
- ○ Hip or Joint Replacement
- ○ HPV
- ○ Jaundice
- ○ Kidney Disease/Dialysis
- ○ Lupus
- ○ Low Blood Pressure
- ○ Malignancies
- ○ Mitral Valve Prolapse
- ○ Neck or Back Problems
- ○ Osteopetrosis
- ○ Pacemaker
- ○ Prosthetic Joints
- ○ Psychiatric Care
- ○ Radiation Treatment
- ○ Respiratory Problems
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Scarlet Fever
- ○ Seizures/Fainting Spells
- ○ Sexually Transmitted Infections
- ○ Sinus Problems
- ○ Stomach Ulcers
- ○ Stroke
- ○ Thyroid Disease
- ○ Tuberculosis
- ○ Ulcers
- ○ Other: (Please specify) _____ _____

## Medical Questionnaire

Generally, are you in good health? **Yes** **No**

List any medications that you are taking including nonprescription drugs, supplements, natural products, and/or vitamins:

_____

_____

_____

_____

**ALLERGIES/SENSITIVITIES:**

☐ Aspirin ☐ Local Anesthetic
☐ Bananas ☐ Metals
☐ Codeine ☐ Penicillin
☐ Latex ☐ Red Dye
☐ Other Dental Materials: _____

Are you allergic to any medications? **Yes** **No**

If yes, please list: _____

_____

Other allergies: _____

_____

Date of last medical exam: _____

Are you currently under the care of an MD? **Yes** **No** If yes, what for? _____

Have you ever been hospitalized? **Yes** **No** If yes, what for? _____

Have you ever had a transplant operation that has depressed your immune system? **Yes** **No** _____

Do you: ☐Smoke or chew tobacco? ☐Use a vaporizer? ☐Use marijuana? If yes, how much in one day? _____

Are you interested in stopping? **Yes** **No**

Are you taking or have you ever taken bisphosphonates? Fosmax or Actone for osteoporosis, chemotherapy, etc.?

**Yes** **No** If yes, is it taken orally or by IV? _____

Are you pregnant? **Yes** **No** Expected delivery date: _____ Are you nursing or breastfeeding? **Yes** **No**

Is there a possibility of pregnancy? Yes No Are you taking birth control pills? **Yes** **No**

***NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.***

## Dental History Information

Name of your previous dentist: _____

Date of last dental visit: _____

Date of last radiographs (x-rays): _____

Date of last dental cleaning: _____

Reason for today's visit: ☐ Emergency ☐ Check-up ☐ Other: _____

Do you have a history of:

- ○ Bad breath
- ○ Bleeding gums
- ○ Broken fillings
- ○ Dry mouth
- ○ Fingernail biting
- ○ Frequent headaches
- ○ Grinding/clenching your teeth
- ○ Jaw tenderness
- ○ Loose teeth
- ○ Mouth breathing
- ○ Popping/clicking near your ear when chewing
- ○ Sensitivity to hot, cold, or pressure
- ○ Sores/blisters/swelling on gums, lips, or cheeks

How often do you brush your teeth? _____ Floss? _____ Do you use an electric toothbrush? **Yes** **No**

Do you snore? **Yes** **No** Do you use an appliance to prevent snoring? **Yes** **No** If yes, what? _____

Have you ever:

Been treated for periodontal disease? **Yes** **No**

Had an oral cancer screening? **Yes** **No**

Had orthodontic treatment (e.g. braces)? **Yes** **No** If yes, please specify: _____

Had complications from extractions? **Yes** **No** If yes, please specify: _____

Used nitrous oxide or oral sedation for dental appointments? **Yes** **No** If yes, please specify: _____

On a scale of 1 to 10, with 10 being the highest, how important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

On a scale of 1 to 10, with 10 being the highest, how anxious are you at the dentist office?

1 2 3 4 5 6 7 8 9 10

Is there anything about your smile that you want to change? **Yes** **No** If yes, please specify: _____

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## General Release Statement

I certify that I have read, understood, and accurately completed the personal medical and dental histories to the best of my knowledge and have not knowingly omitted any information. This information has been reviewed with me, and I consent to my physician being contacted regarding specific medical questions. I authorize the dentist to perform necessary diagnostic procedures and treatment as required to achieve the proper level of dental care.

I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

Payments are to be made at each visit for services rendered.

Cash, Debit, Mastercard and Visa are acceptable forms of payment.

Interest of 2% per month on late payments will be charged automatically.

*Patient/Guardian Name* _____ *Date* _____

*Signature* _____ *Reviewed by Dentist* _____

## *PATIENT CONSENT FORM*

The privacy of your personal information is a vital part of our office ensuring that you receive 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 important to us to provide this service to our patients.

All staff members who encounter 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.

Please do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff member in our office is committed to ensuring that you receive the best quality of care.

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

I agree that Centre Wellington Dental can collect, use and disclose personal information about _____
Print Name
as set out above in the information about the office's privacy policies.

_____
Signature

_____
Signature of Witness

_____
Date

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## *AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND RADIOGRAPHS*

I, _____, give authorization to the release of myself and/or my family's dental radiographs
Print Name
and a copy of any pertinent treatment records that may assist in a smooth transition of my dental care to Centre Wellington Dental.

Previous Dentist: _____

Past Office Phone Number: _____

Fax or Email: _____

**Office Use Only: Please indicate last dates for the following.**

**Patient's Name(s):** _____

**Date of birth:** _____

Please release the following:

- Any full mouth series
- Bitewing radiographs and PAs taken within the last 2 years
- Any available Panoramic radiographs

Please provide the following information:

New Patient Exams (01101, 01102, 01103): _____

Recall (01202): _____

Bitewings (02142): _____

Panoramic (02601): _____

Signature of Patient: _____

Thank you,

*Centre Wellington Dental*