Centre Wellington Dental

71-D James Street • Elora, Ontario • N0B 1S0

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 staff members are 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 send them back 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 could be implemented on appointments cancelled without 24 hours' notice.

Sincerely,
Dr. Kirk Tofflemire
Dr. Danielle Walker
Dr. Emily Israel
Dr. Shruti Patel
Dr. Alvina Siu

Patient Information

PLEASE PROVIDE HEALTH CARD AND INSURANCE CARD (if applicable) TO FRONT DESK PERSONNEL

First Name: _____ MI: ___ Last: _____ Preferred Name: _____

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

Email Address: _____ Date of Birth: _____

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

Name of Physician: _____ Physician's Phone: _____

In case of Emergency Contact: _____ Relationship: _____ Phone: _____

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

Do you have Dental Insurance Coverage? Yes No If yes, please provide us with your card

How did you hear about our office? _____

Patient Health History

Do you have a history of:

- ☐ A.I.D.S/HIV Positive
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bone Disease
- ☐ Cancer
- ☐ Chest Pain
- ☐ Circulatory Problems
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ 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
- ☐ Kidney Dialysis
- ☐ Latex Sensitivity
- ☐ Lupus
- ☐ Low Blood Pressure
- ☐ Malignancies
- ☐ Mitral Valve Prolapse
- ☐ Neck and Back Problems
- ☐ Pacemaker
- ☐ Prosthetic joints
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems/Disorders
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures/Fainting Spells
- ☐ Sinus Problems
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or growths
- ☐ Ulcers
- ☐ Venereal Disease

Medical Questions

Are you in good health? Yes No

List any medications that you are taking including nonprescription drugs: _____

_____

Are you allergic to any medications? Yes No If yes, please list: _____

Have you ever had an allergic reaction to Bananas, Latex or Dental Materials? Yes No _____

Date of last medical exam: _____

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

Do you have any disease/problem you think we should know about? Yes No _____

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

Do you smoke or chew tobacco? Yes No If yes, what and how much in one day? _____ Are you interested in stopping? Yes No

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

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? _____

FOR WOMEN ONLY

Are you taking birth control pills? Yes No

Are you pregnant? Yes No Expected delivery date: _____

Is there a possibility of pregnancy? Yes No Are you Nursing/breastfeeding? 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

Date of your last dental visit? _____

Name of your previous dentist: _____

Reason for today's visit? _____

Have you ever had an oral cancer screening? Yes No _____

How often do you brush your teeth? _____

How often do you floss your teeth?_____

Do your gums bleed? _____

Have you or a family member ever been treated for periodontal disease? Yes No _____

Have you ever had complications from extractions? Yes No _____

Have you ever had popping or clicking near your ear when chewing? Yes No _____

Are you prone to frequent headaches? Yes No _____

Do you grind or clench your teeth? Yes No _____

Do you have sores, blisters or swelling on your gum's lips or cheeks? Yes No _____

Have you ever had orthodontic (i.e. braces) treatment? Yes No _____

Do you snore? Yes No Do you use an appliance to prevent snoring? Yes No _____

Do you have problems with bad breath? Yes No

Have you ever had an allergic reaction to a crown, metal fillings or dental appliance? Yes No _____

Have you ever used an electric toothbrush? Yes No

Are your teeth sensitive to hot, cold or pressure? Yes No _____

On a scale from 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

Is there anything you want to change about your smile? _____

_____

On a scale from 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

Have you ever used nitrous oxide or oral sedation for dental appointments? Yes No _____

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 of 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

Privacy of your personal information is an important part of our office providing you with 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 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 every staff person in our office is committed to ensuring that you receive the best quality dental 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 _____
as set out above in the information about the office's privacy policies. **Print Name**

_____
Signature

_____
Signature of witness

_____
Date

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

Dear Dr. _____

Phone #: _____ Fax or Email: _____

Office Use Only:

Patient's Name(s): _____

_____

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): _____

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

Signature of Patient: _____

Thank you,
Centre Wellington Dental

Patient Acknowledgement:
COVID-19 Pandemic Emergency Dental Risk

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus ***may not show symptoms and still be contagious***. For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible. _____ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize it is **not possible to maintain this distance while receiving dental treatment.** _____ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. _____ (initial)

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, **that I have an elevated risk of contracting the novel coronavirus simply by being in the dental office.** _____ (initial)

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: (i) fever, (ii) new or worsening cough, (iii) sore throat, (iv) runny nose or (v) headache. _____ (initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. _____ (initial)
If applicable, approximate date of test: _____

I confirm that I am not waiting for the results of a test for COVID-19. _____ (initial)

I confirm that this is not currently a period during which public health authorities required I self-isolate for 14 days. _____ (initial)

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to have emergency surgical/dental treatment completed during the COVID-19 pandemic.

PRINT Name: _____

SIGNATURE OF PATIENT: _____ Date: _____

Adapted from Dental Association of PEI/ Ontario COVID-19 Pandemic Emergency Dental Risk Acknowledge by Patient.