



PARK HAVEN DENTAL

Welcome

Medical Alert []

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

Patient Information A parent or guardian will be responsible for decisions on my treatment [] Yes [] No

Name: _____ Date of Birth: ____/____/____
First Initial Last D M Y

Address: _____
Street Apt. City Prov. Postal Code

Home Tel. (____) _____ Work Tel. (____) _____ Cell (____) _____

Email: _____

Referred by: _____

Emergency Contact: _____ Tel. (____) _____

Family Doctor: _____ Tel. (____) _____

Financial Information Method of payment: Cash [] Credit Card [] Insurance [] Other []
Person responsible for financial matters: Self [] Spouse [] Parent/Guardian [] Other []

IF DIFFERENT FROM ABOVE
Name: _____
Address: _____
Date of Birth: ____/____/____ Home Tel. (____) _____ Work Tel. (____) _____
D M Y

Driver's Lic.: _____ OR ID#: _____

PRIMARY INSURANCE
Ins. Company: _____ Employer: _____
Policy Holder: _____ Date of Birth: _____
Policy#: _____ Certificate#: _____

SECONDARY INSURANCE
Ins. Company: _____ Employer: _____
Policy Holder: _____ Date of Birth: _____
Policy#: _____ Certificate#: _____

Medical History (this information will remain confidential)

Date _____

- | | YES | NO |
|--|---|--|
| 1. Are you presently under the care of a physician? If so, explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized? Explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. When was your last medical check up? _____ | | |
| 4. Are you taking any drugs or medication at this time?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any allergies?
Please ✓ appropriate boxes. <input type="checkbox"/> NONE <input type="checkbox"/> Local Anaesthetic <input type="checkbox"/> Latex / Rubber Products <input type="checkbox"/> Antibiotics <input type="checkbox"/> Other | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you bruise easily or have prolonged bleeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have or have you ever had asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you ever had any heart or blood pressure problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a prosthetic or artificial joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever had hepatitis, jaundice or liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you smoke or chew tobacco products? How much per day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever fainted, had shortness of breath or chest pains? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. WOMEN Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Using birth control? Yes <input type="checkbox"/> No <input type="checkbox"/> Reached menopause? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 17. Do you have or have you ever had any of the following? Please ✓ appropriate boxes. NONE <input type="checkbox"/> | | |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Osteoporosis Medications (e.g. Fosomax, Actonel) | <input type="checkbox"/> Seizures (epilepsy) |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Steroid Therapy |
| | | <input type="checkbox"/> Arthritis |
| | | <input type="checkbox"/> Tuberculosis |
| | | <input type="checkbox"/> Thyroid Disease |
| 18. Are there any conditions or diseases not listed above that you have or had? If so what? _____ | | |

Dental History

1. What is the reason for today's visit? Emergency Examination Other _____
2. How frequently do you see a dentist? 3-6 months Annually Other _____
3. When was your last dental visit? _____ Last X-Ray? _____
4. How often do you brush per day? _____ Floss? _____ Use anti-bacterial rinse? _____
5. Are your teeth sensitive to: Cold Sweets Heat Other _____
6. Do your gums bleed when: Brushing Flossing Never
7. Do your jaws crack or pop when you open widely?.....
8. Do you grind or clench your teeth?.....
9. Are you nervous during dental treatment?.....
10. Would you prefer sedation for dental treatment?.....
11. Have you ever had any problems with previous dental treatments? Specify _____
12. Have you ever had any of the following: Bridgework Crowns or Caps
 Full or Partial Dentures Orthodontic (braces) Periodontal (Gums) Treatment Root Canal
13. Are you satisfied with your teeth? Specify _____

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

Signature Self Parent/Guardian

Print name

Date

Dentist Signature

Print name

Date

Thank you



150 Oak Park Blvd, Unit 9
Oakville, ON, L6H 3P2

 905-257-2555
 289-725-7981

info@parkhavendental.ca
www.parkhavendental.ca

MEDICATIONS LIST

Are you currently taking any medications? Yes _____ No _____

If you marked 'yes', please list your medications:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Signature: _____

Date: _____

Dentist Signature: _____



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PAYMENT POLICY

The full payment for services rendered within the office is expected at the end of each appointment. For your convenience, our office will send an electronic estimate ahead of time to your insurance company and then bill directly to them upon completion of the procedure. If the claim is not processed electronically, then we will ask for your signature on the appropriate forms so we can mail out a hard copy of the dental claim to your insurance.

For any charges that are not covered by your insurance or if you do not have dental insurance, you will be responsible for the remaining cost. We accept Visa, Mastercard, American Express, Debit, and Cash.

CANCELLATION POLICY

Please always arrive on time for your appointment. If you are running a few minutes late, please call our office to let us know. If you are significantly delayed, we may only be able to complete a partial treatment or may even have to ask you to reschedule depending on the remaining time left before the following patient's appointment.

We require at least 48 hours (or 2 business days) notice to cancel or reschedule your appointment. This allows us time to fill in the schedule in an attempt not to waste our dentists' and hygienists' time. We will try to be understanding to last minute cancellations for unexpected medical or personal emergencies, but repeat occurrences of last-minute cancellations or no-shows to your appointments will incur a \$50.00 fee for the disruption.

I have read and understand the terms indicated above.

Signature: _____

Date: _____

COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Our office understands the importance of protecting your personal information.

We will collect, use and disclose information about you for the following purposes:

- Enable us to contact you (your child) to book and confirm appointments.
- To advise you of treatment options
- To communicate with other health-care providers, including medical and dental specialists and general practitioners
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to the Royal College or Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the *Regulatory health professions act*.
- To comply with agreements/undertakings entered into voluntarily by Dr. Ngoc D Steve Van, Dr. Puneet Gill or their associates 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 prepare material for the Health Professions Appeal and Review Board
- To process credit card payments
- To collect unpaid accounts.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the consequences of that decision, and the process.

By signing the consent section of this form, you have agreed that you have given your informed consent to collection, use and/or disclosure of your personal information for the purposes that are listed.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information. I agree that Dr. Ngoc D Steve Van, Dr. Puneet Gill or their associates can collect, use and disclose personal information as set out above in the information about the office's privacy policies according to the requirements of the Regulated Health Professions Act, the Royal College of Dental Surgeons and privacy legislations.

Print Name

Signature

Date

Signature of Witness