Welcome

Bradford DENTAL Care

Your cooperation in completing this questionnaire is essential to providing you with the highest standard of care. If you have any questions, please ask our staff who are available to assist you with the completion of this form. All information is strictly confidential and will remain with this office.

PLEASE PRINT TODAYS DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ SEX: □ MALE □ FEMALE
LAST *FIRST* *MIDDLE INITIAL*

□ MARRIED □ SINGLE □ CHILD □ OTHER _____ DATE OF BIRTH: _____ AGE: _____
MM DD YY

ADDRESS: _____
STREET *APT #* *BOX #*

_____
CITY *PROVINCE* *POSTAL CODE*

PHONE (HOME): _____ (CELL): _____

EMAIL: _____

OCCUPATION: _____ (WORK): _____ EXT: _____

HEALTH INFORMATION

NAME OF PREVIOUS DENTIST: _____ DATE OF LAST VISIT: _____

REASON FOR TODAYS VISIT: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE √ THOSE THAT APPLY

□ AIDS/HIV
□ ANEMIA
□ ARTHRITIS
□ ARTIFICIAL JOINTS
□ ASTHMA
□ BLOOD DISEASE
□ CANCER
□ DIABETES
□ DIZZINESS
□ EPILEPSY
□ EXCESSIVE BLEEDING
□ FAINTING
□ GLAUCOMA
□ GROWTHS
□ HAY FEVER
□ HEAD INJURIES
□ HEART DISEASE
□ MITRAL VALVE PROLAPSE
□ MIGRANE HEADACHES
□ HEPATITIS A B C
□ HIGH BLOOD PRESSURE
□ JAUNDICE
□ JOINT REPLACEMENT
□ KIDNEY DISEASE
□ LIVER DISEASE
□ MENTAL DISORDERS
□ NERVOUS DISORDERS
□ PACEMAKER
□ PREGNANCY, DUE DATE: _____
□ RADIATION TREATMENT
□ RESPIRATORY PROBLEMS
□ RHEUMATIC FEVER
□ RHEUMATISM
□ SINUS PROBLEMS
□ SMOKING, HOW LONG: _____
□ STOMACH PROBLEMS
□ STROKE. WHEN: _____
□ THYROID CONDITION
□ TUBERCULOSIS
□ TUMORS
□ ULCERS
□ VENEREAL DISEASE

ALLERGIES:

□ PENICILLIN □ CODEINE □ ASA □ SULPHA □ LATEX

□ METALS □ LOCAL ANAESTHETIC

□ OTHER: _____

MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD TO MAKE YOUR VISITS MORE COMFORTABLE?

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? □ Another patient: _____

Have you ever had any complications following dental treatment? □ NO □ YES, PLEASE EXPLAIN: _____
Have you been to a hospital or needed emergency care during the past two years? □ NO □ YES, PLEASE EXPLAIN: _____

Name of physician: _____ Phone #: _____

Do you have any health problems that need further clarification? □ NO □ YES, Please explain:

Special concerns

Are you nervous about dental treatment?	□ Yes □ No
would you like more information on tooth whitening?	□ Yes □ No
would you like more information on braces?	□ Yes □ No
Are you aware of night time tooth grinding?	□ Yes □ No
Do you require a sports mouth guard?	□ Yes □ No

IF SOMEONE ELSE IS RESPONSIBLE FOR YOUR ACCOUNT, PLEASE FILL IN THIS BOX

NAME OF PERSON RESPONSIBLE FOR ACCOUNT: _____
Last *First*

Relation to patient: □ Spouse □ Child □ Other: _____

Do you have dental insurance? □ No □ yes, please fill out the information below

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURED'S NAME:	INSURED'S NAME:
EMPLOYER NAME:	EMPLOYER NAME:
INSURANCE COMPANY NAME:	INSURANCE COMPANY NAME:
RELATION TO PATIENT: □ SPOUSE □ CHILD □ SELF □ OTHER	RELATION TO PATIENT: □ SPOUSE □ CHILD □ SELF □ OTHER
DATE OF BIRTH: MM: DD: YY:	DATE OF BIRTH: MM: DD: YY:
POLICY/GROUP PLAN #:	POLICY/GROUP PLAN #:
DIVISION:	DIVISION:
CERTIFICATE/ID #:	CERTIFICATE/ID #:

CONSENT, PLEASE INITIAL ALL APPLICABLE ITEMS

_____ I AUTHORIZE RELEASE, TO MY INSURING COMPANY PLAN ADMINISTRATOR AND CDA, THE INFORMATION CONTAINED IN CLAIMS SUBMITTED ELECTRONICALLY

_____ I HEREBY ASSIGN MY BENEFITS PAYABLE FROM CLAIMS SUBMITTED ELECTRONICALLY OR BY MAIL TO DR. MATTHIAS YEH AND DR. JUSTIN CHOW AND AUTHORIZE PAYMENT DIRECTLY TO THEM.

_____ TO THE BEST OF MY KNOWLEDGE, ALL THE PRECEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT, IF I EVER HAVE ANY CHANGE IN MY HEALTH I WILL INFORM THE DOCTORS AT THE NEXT APPOINTMENT WITHOUT FAIL

FINANCIAL POLICIES

→ Your insurance benefits are between you, your employer and your insurance company. Any benefit (deductible, fee guide, In-eligible service or co-payment) **is your responsibility**.
→ All estimates for care are approximate
→ I have read the above conditions of treatment and payment and agree to their content.

_____ _____
Signature of patient/parent/guardian or guarantor of payment *Print name*

_____ _____
Date *Relation to patient*

PATIENT CONSENT FORM

For Collection, Use and Disclosure of Personal Information.

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.

In this office, Jessica K acts as the Privacy Information Officer.

All staff members who review your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate uses and protection of your personal information.

Attached to this consent 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 the existing legislation, and privacy protection protocols
- Our privacy protocols comply with the privacy legislation, standards of our regulatory body, and 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 staff.

Please be assured that every staff person in our office is committed that you receive the best quality dental care.

By signing the consent section of this Patient Consent Form, you have agreed that you have given informed consent to the collection, use and or disclosure of your personal information for the purposes 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 Professional Act 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 circumstances divulge to your Insurer any 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 consent.
When unusual requests are received, we will contact your for your 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.

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 accomplishing that, we have outlined below how our office is using and disclosing your information.

The 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 care
- To provide 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
- To communicate with other health care providers, including your physician, specialists, medical laboratories, and general dentist who are the 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
- To complete and submit dental claims for the third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to the RCDSO in a timely fashion when required.
- To deliver your charts and records to dentist insurance carriers to enable the insurance company to assess liability and quantify damages if any
- To prepare material for the Health Professions Appeal and review board
- To invoice for goods and services
- To call in prescriptions to your pharmacy
- To process credit card payments and collect unpaid accounts
- To comply with the general law
- To allow us to take study models, photos for treatment planning.

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 agree that BRADFORD DENTAL CARE can collect, use and disclose personal information

about _____ as set out in the above information.
Print Patient Name

_____ _____
Patient Signature/Guardian Signature *Date*

Bradford DENTAL Care
CHOW YEH DENTISTRY PROFESSIONAL CORP.
Tel: 905-775-5553

Cancellation Policy

To all our patients:

Dr. Yeh and Dr. Chow and their team at Bradford Dental Care have always been concerned with the rising cost of health care. Broken appointments and short notice cancellations create a great deal of scheduling problems and drive the cost of dental services up. Your appointments have been set aside specifically for you. It is very difficult to fill these appointments with little or no notice, or even with a days notice.

We understand emergency situations when they arise, but we would appreciate 48 hours notice if you must reschedule appointments. **We will charge a fee of $50 for any missed or frequently cancelled appointments**.

This letter serves your notification that if there are any missed appointments, we will charge a reservation fee for each family member. Reservation fees will need to be paid prior to rescheduling.

Sincerely,

The Bradford Dental Care Team

I have read and understand the above cancellation policy.

_____ _____

Signature
Date