OGILVIE DENTAL

Patient Information

Patient Name: ____Date:_________________
Last First MI

☐ Female ☐ Single ☐ Child
☐ Male ☐ Married ☐ Other _______________________Birth Date _______/_______/_________
Day Month Year

Address: ____
Street Apartment #

____
City Province Postal Code

(Home Phone): ___________________ (Work): _________________Ext:________ (Cell): ___________________

Email: ____

Health Information

Date of last dental visit: _________________ Reason for today's visit: _______________________________

I would like to know more about the following services: Please check those that apply:

☐Tooth Whitening ☐ Crowns ☐ Dentures ☐Root Canal ☐ Braces☐ Implants ☐ Bridges ☐Veneers
☐ Periodontal/Gum Disease ☐Snoring ☐Sleep Apnea ☐ TMJ ☐ Night Guard☐Sports Guard
☐ Extractions ☐Fillings ☐ Cosmetic Dentistry ☐Other Please Specify:______________________

Do you or have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ ADD/ ADHD
☐ Angina
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness/Vertigo
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Fibromyalgia
☐ Glaucoma
☐ Head or Neck Injuries
☐ Heart Disease
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV
☐ Joint Replacement
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorder
☐ Nervous Disorder
☐ Organ Transplant
☐ Pacemaker
☐ Pregnant (Currently)
Due date__________
☐ Radiation Therapy
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Spine or Back Injuries
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tobacco Use
☐ Tuberculosis
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Allergy to other meds:
____
____

What medications are you taking? ____
Do you have any allergies to medications? ☐Yes ☐ No ____
Any other condition we should be aware of? ☐ Yes☐ No ____
Family Physician: ____ Phone: ________________________
Have you undergone any surgery in the past five years?☐Yes ☐ No ____________________________________
Emergency Contact Person: _______________________Phone: ____________________Cell: ________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor as soon as possible without fail.

Signature of Patient, Parent or Guardian____________________________________Date____________________

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Referral Information

Whom may we thank for referring you to our office?

☐ A Patient ☐ A Relative ☐ A Friend ☐ A Co-Worker ☐ Sign / Location ☐ Newsletter ☐ Yellow pages
☐ Magnet ☐ Other___________________ ☐Internet / Google, Please specify: _________________________
Please name person who has referred you to our practice: ____

INSURANCE INFORMATION

PRIMARY	SECONDARY
Subscriber's Name: _________________________	Subscriber's Name: __________________________
Date of Birth: _______________________________	Date of Birth: _______________________________
Insurance Name: ____________________________	Insurance Name: ____________________________
Group/Plan #: ______________________________	Group/Plan #: _______________________________
Insurer's ID #: ______________________________	Insurer's ID #: ______________________________
Employer's Name: ___________________________	Employer's Name: ____________________________
Relationship to Insured:	Relationship to Insured:
☐Self ☐ Spouse ☐ Child ☐Other: ____________	☐Self ☐ Spouse ☐ Child ☐ Other: ______________

CONSENT FOR SERVICES

Office Financial Policy

Ogilvie Dental is a fee-for-service practice: we ask for payment in full on the day a service is rendered. If you have dental insurance we will gladly submit a claim electronically to your insurance, who will then reimburse you. However, you remain responsible to pay for any services rendered. Upon request a written estimate for any proposed work will be given to you and/ or submitted to your insurance.

Office Cancellation Policy

In order to maintain the best quality services for all our patients, we require two business days notice for any cancellations. Any appointment that is cancelled or missed without two business days notice and every such missed appointment thereafter, a $50.00 charge will apply. In fairness to our other patients who expect and deserve timely services, we ask for your cooperation in this matter.

I have read the above conditions and agree to their content.

____   ________________________   ______________________
Signature of patient, parent or guardian   Date   Relationship to patient

OGILVIE DENTAL

PRIVACY OF INFORMATION/PATIENT CONSENT FORM

- We respect your right to privacy, 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, privacy protection protocols and with the RCDSO.
- Many safeguards have been placed to protect your information.
  - Do not hesitate to discuss our policy with any member of our staff.

How our office collects, uses and discloses patients' personal information

We understand the importance of protecting your personal information. We have outlined here how our office is using and disclosing your information.

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

- To communicate with other treating health-care providers, including specialists and general dentists.
- To submit dental claims for third party consideration and payment ie: dental insurance, etc..
- To help in obtaining a proper diagnosis and appropriate treatments for you the patient.

By signing the consent section of this Patient Consent Form, you have agreed that you have fully read and understood this consent form and that you agree to the collection, use, and/ or disclosure of your personal information for the purposes that are listed.

Your information may be accessed by regulatory advisors under the terms of the Regulated Health Professions Act (RHPA) for purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under RHPA, and for the defence of a legal issue.

Our office will not under any condition supply your insurer with your confidential medical history. In the event that this kind of request is made, we will contact you for permission to release such information. We may also advise you if such 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 form that explains how this office will use any personal information.
I agree that Dr. Patrick Miron, as privacy director for this dental office, can collect, use and disclose personal information on my behalf, as set out in the above office privacy policies.

______________________________	______________________________
Signature of patient, parent or guardian	Relationship to patient
______________________________	______________________________
Print name	Date
______________________________	
Witness	