



PATIENT REGISTRATION

Patient Name: _____ Adult Child Date of Birth: _____

PATIENT INFORMATION

Marital Status:

Single Married Common-Law Other

Spouse/Partner's Name: _____

Address: _____

City: _____ Postal Code: _____

Occupation: _____

Do you have family members or friends that are patients of this office?

Yes No _____

Referred by: _____

Health Card # _____

CONTACT INFORMATION

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail Address: _____

Please indicate the best time to contact you for appointments:

Any Time/Any Day Days Only

Evenings Only Weekends

Preference for method of contact: Phone E-mail Text

In case of an emergency, contact:

Name: _____

Relationship: _____ Phone: _____

RESPONSIBLE PARTY

Self *Spouse *Other _____

*Please complete information below

Name: _____

Address: _____

City: _____ Postal Code: _____

Employer: _____

Phone: Home _____ Work _____

Is this person currently a patient at our office? Yes No

DENTAL INSURANCE (PRIMARY COVERAGE)

Employee Name: _____

Employee Date of Birth: _____

Employer: _____ # Yrs: _____

Insurance Company: _____

Address: _____

Phone: _____

Group Policy No. _____

Certificate or ID No. _____

DENTAL INSURANCE (ADDITIONAL COVERAGE)

Employee Name: _____

Employee Date of Birth: _____

Employer: _____ # Yrs: _____

Insurance Company: _____

Address: _____

Phone: _____

Group Policy No. _____

Certificate or ID No. _____

PAYMENT INFORMATION

Method of Payment:

Insurance Cash Cheque Credit Card

Coverage:

Basic _____ % Ortho _____ %

Major _____ % Endo _____ %

Other _____ % Perio _____ %

Maximum Coverage _____

Check-up Frequency: Every _____ Months

INFORMED CONSENT

GENERAL RELEASE

diagnostic procedures and treatmentsevaluating and administering claims for insurance benefitsanother dentistpayment of insurance benefits directly to the dentistI agree to be responsible for payment of services not paidsetting up of my dental filesmy file will be kept in the office at all timesaccuracy of the informationSignature of Patient or Parent/Guardian Date

MEDICAL/DENTAL INFORMED CONSENT

I hereby promise to inform my dentist of any changes to my health status.

Signature of Patient or Parent/Guardian

Date

SIGNATURE ON FILE

Signature of Patient or Parent/Guardian

Date



MEDICAL HISTORY

DENTISTRY AT
Lifestyles

Patient Name: _____ Date of Birth: _____

Family Physician: _____ Office Phone: _____

Have you had a medical exam in the last 12 months? YES NO

Date of last exam: _____

Have there been any changes in your general health within the past year? YES NO

Have you ever been hospitalized? YES NO

Are you now receiving medical treatment? YES NO

Are you presently taking any form or medication? YES NO

Have you ever been diagnosed or treated for cancer? YES NO

Have you ever had heart problems or heart disease? YES NO

Do you or have you ever taken illegal drugs? YES NO

Have you ever taken diet pills? YES NO

Do you smoke or chew tobacco? YES NO

Would you like to speak to your dentist privately? YES NO

Are you allergic to or have you had a reaction to:

Local Anesthetics	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Antibiotics	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin/Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Metals	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
Specific Foods	<input type="checkbox"/>	<input type="checkbox"/>	Flavors (e.g. Mint)	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

DOCTOR'S COMMENTS

— MEDICAL ALERT —

Have you ever had and/or been treated for:

High Blood Pressure	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Emphysema/Bronchitis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Recent Weight Loss/Gain	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis/Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles/Feet/Hands	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Infections	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lens	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma/Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A/B/C	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble/Frequent Cold	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blister	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Dependence	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints/Implants	<input type="checkbox"/>	<input type="checkbox"/>
						Anemia	<input type="checkbox"/>	<input type="checkbox"/>
						Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
						Excessive Bruising	<input type="checkbox"/>	<input type="checkbox"/>
						Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>

WOMEN ONLY: YES NO

Are you pregnant or think you are pregnant?

Are you nursing?

Are you taking oral contraceptives?

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient or Parent/Guardian Signature: _____ Date: _____

Treating Dentist's Signature: _____ Date: _____



CHILD MEDICAL/DENTAL HISTORY

DENTISTRY AT
Lifestyles

Patient Name: _____ Date: _____

Parent/Guardian's Name: _____ Patient's Date of Birth: _____

Family Physician Name: _____ Phone: _____ Last Exam: _____

Previous Dentist's Name: _____ Phone: _____ Last Visit: _____

MEDICAL HISTORY

- | | YES | NO |
|--|--------------------------|--------------------------|
| Does your child have a health problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child presently receiving medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is your child presently taking medication? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child have a history or allergies, sensitivities or adverse reactions to any drugs/medications/substances? | <input type="checkbox"/> | <input type="checkbox"/> |

DOCTOR'S COMMENTS

Has your child ever had any of the following conditions?

- | | YES | NO | | YES | NO | | YES | NO |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|
| AIDS / HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Earaches | <input type="checkbox"/> | <input type="checkbox"/> | Mumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Muscular Dystrophy | <input type="checkbox"/> | <input type="checkbox"/> |
| Behavioral Problems | <input type="checkbox"/> | <input type="checkbox"/> | Handicaps / Disabilities | <input type="checkbox"/> | <input type="checkbox"/> | Nervous Disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Chicken Pox | <input type="checkbox"/> | <input type="checkbox"/> | Heart Troubles | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Birth Defect | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Speech Impairments | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Heart Defect | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems | <input type="checkbox"/> | <input type="checkbox"/> | Strep Throat | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Seizures / Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Liver Problems | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive Bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Lung Problems | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |

DENTAL HISTORY

- | | YES | NO |
|--|--------------------------|--------------------------|
| Is this your child's first visit to a dentist? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever had a mouth injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever had orthodontics? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your child have any of the following habits? | | |
| Thumb Sucking | <input type="checkbox"/> | <input type="checkbox"/> |
| Lip Biting | <input type="checkbox"/> | <input type="checkbox"/> |
| Nail Biting | <input type="checkbox"/> | <input type="checkbox"/> |
| Mouth Breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaw Clenching | <input type="checkbox"/> | <input type="checkbox"/> |
| Teeth Grinding | <input type="checkbox"/> | <input type="checkbox"/> |
| Tongue Thrusting | <input type="checkbox"/> | <input type="checkbox"/> |
| Chew Hard Objects | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever received a local anesthetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child had difficulty with previous dental visits? | <input type="checkbox"/> | <input type="checkbox"/> |
| How often does your child brush his/her teeth? _____ | | |
| How often does your child floss? _____ | | |

DOCTOR'S COMMENTS

Parent's Signature: _____



DENTISTRY AT *Lifestyles*

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.

Personal information is information about an identifiable individual. Personal information includes information that relates to their personal characteristics (e.g. gender, age, home address, ethnic background), their health or their activities and views. Personal information is to be contrasted with business information which is not protected by privacy legislation.

In the office, the Office Manager acts as the Privacy Information Officer. 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 your 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 or 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 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 your treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services to 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 and debit 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 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 Professionals Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defence 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, 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 Dentistry at Lifestyles Professional Corporation can collect, use and disclose personal information about myself and my immediate family as set out above in the information about the office's privacy policies.

Signature

Print Name

Date

Signature of Witness



DENTISTRY AT
Lifestyles

During the course of your treatment at Dentistry at Lifestyles we take several radiograph images, intra oral and extra oral photos for diagnostic and treatment planning purposes. These images are kept confidential unless you authorize Dentistry at Lifestyles to use these photos for educational reasons on printed material, to show other patients or on our office website. Relevant personal information may be used in conjunction with the images, such as age, gender, and dental history to support the image. Your name will not be disclosed unless expressed by you. Please complete this consent form, sign it and date it.

I authorize the use of my images and pertinent personal information such as age, gender and dental history (the use of my name will be held confidential)

I do not authorize the use of my images or any relevant supporting information.

Patient Signature (or signature of guardian)

Date



DENTISTRY AT
Lifestyles

Canada's new anti-spam legislation (CASL) took effect July 1, 2014. This law prohibits the sending of any type of electronic message that is commercial in nature unless the recipient has provided consent first.

As a result we require your consent to send you electronic messages from our office which may contain appointment information and newsletters. Please complete this form.

I consent to receiving electronic messages

I do not consent to receiving electronic messages

Signature

Date



DENTISTRY AT
Lifestyles

FINANCIAL POLICY

1. It is your responsibility as the patient to pay for services rendered.
2. Payment for the services rendered will be required at the end of your appointment.
3. Options for payment include cash, debit or credit card.

PATIENTS WITH INSURANCE COVERAGE:

1. It is your responsibility as the patient to understand the contract between your Employer and the Company providing the benefits.
2. Payment for the services rendered on your **FIRST** visit will be required at the end of your appointment. We will be happy to assist you by submitting your claim to your Insurance Company by mail or electronically. Any consecutive appointments will follow protocols indicated in #3 and #4.
3. It is your responsibility to pay the amount not covered by your Insurance Company, at the end of your appointment.
4. If your account is not paid within 30 days after your payment date, a 2% monthly interest charge will be applied.

*Please note, some treatment options will have different specific financial policies. (Sedation, Implant Treatment and Surgery). Our Treatment Coordinator will be happy to review these with you, should you ever require these treatment options.

I understand that the treatment proposed by Dr. Augimeri or associates is not necessarily in accordance to my Insurance Policy, and that the Doctor's suggestions for treatment will not be based upon my Insurance coverage, but will be based on my oral health care needs.

I understand that I have the right to agree or to refuse any proposed treatment.

I understand that proposed treatment by Dr. Augimeri or associates may not be covered by my Insurance Policy, and that it is my responsibility to pay for any treatment that I have agreed to, and to pay any balances that my Insurance Company does not reimburse.

I, _____ understand and agree to the aforementioned terms.

Signature

Date

Witness

Date