DENTISTRY AT
Lifestyles

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

(Please see reverse)

DENTISTRY AT
Lifestyles

INFORMED CONSENT

GENERAL RELEASE

- I authorize the dentist to perform *diagnostic procedures and treatment* as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of *evaluating and administering claims for insurance benefits*
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to *another dentist*.
- I authorize *payment of insurance benefits directly to the dentist* or dental group, otherwise payable to me.
- I understand that my dental care insurance company may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I *agree to be responsible for payment of services* not *paid, in whole or in part by my dental care payer*.
- I authorize the *setting up of my dental file,* its follow-up, as well as my registration on the recall list(s) of the treating dentist(s).
- I have been informed that *my file* will be kept in the office at all times and that only the dentist(s) and his/her (their) auxiliary personnel will have access to it.
- I attest to the accuracy of the information on this registration form.

_____ _____

Signature of Patient of Parent/Guardian Date

MEDICAL/DENTAL INFORMED CONSENT

- I, the undersigned certify that I have provided, to the best of my knowledge , an accurate and complete medical & dental history and have not knowingly omitted any information. I consent to my dentist obtaining from other practitioners who are currently treating me or have treated me, such further information as maybe necessary for providing me with proper dental treatment and care. *I hereby promise to inform my dentist of any changes to my health status*.

_____ _____

Signature of Patient of Parent/Guardian Date

SIGNATURE ON FILE

- I authorize release to my insuring company(s) plan administrator(s) the information contained in claims submitted electronically.
- I hereby assign my benefits payable from claims submitted electronically to Dr. _____ and authorize payment directly to him/her.

_____ _____

Signature of Patient of Parent/Guardian Date

DENTISTRY AT
Lifestyles

MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Family Physician: _____ Office Phone: _____

	YES	NO
Have you had a medical exam in the last 12 months?	☐	☐
Date of last exam: _____		
Have there been any changes in your general health within the past year?	☐	☐
Have you ever been hospitalized?	☐	☐
Are you now receiving medical treatment?	☐	☐
Are you presently taking any form or medication?	☐	☐
Have you ever been diagnosed or treated for cancer?	☐	☐
Have you ever had heart problems or heart disease?	☐	☐
Do you or have you ever taken illegal drugs?	☐	☐
Have you ever taken diet pills?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Would you like to speak to your dentist privately?	☐	☐

DOCTOR'S COMMENTS

— MEDICAL ALERT —

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

	YES	NO		YES	NO
Local Anesthetics	☐	☐	Antibiotics	☐	☐
Sulfa Drugs	☐	☐	Sedatives	☐	☐
Iodine	☐	☐	Aspirin/Codeine	☐	☐
Metals	☐	☐	Latex Rubber	☐	☐
Specific Foods	☐	☐	Flavors (e.g. Mint)	☐	☐

Other: _____

Have you ever had and/or been treated for:

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

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: _____

DENTISTRY AT
Lifestyles

DENTAL HISTORY

Patient Name: _____ Date: _____

Previous Dentist's Name: _____ Office Phone: _____

Date of your last dental visit: _____ Last Dental Cleaning: _____ Last X-Rays: _____

How often were you seeing your dentist? ❑ Every _____ Months ❑ Yearly ❑ When Needed ❑ Other _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

How would you rate your dental health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Unsure

Please indicate if you have had any of the following treatments:

❑ Oral Hygiene Treatment
❑ Surgical Treatment/Extraction
❑ Partial and/or Complete Denture
❑ Crown and/or Bridge
❑ Root Canal Treatment
❑ Dental Fillings
❑ Orthodontic Treatment
❑ Gum Treatment
❑ Dental Implants
❑ X-Rays
❑ Bite Adjustment
❑ Other _____

	YES	NO
Are you currently having and pain or discomfort?	❑	❑
Do your gums bleed while brushing/flossing or eating?	❑	❑
Do you have sensitive teeth?	❑	❑
❑ Hot ❑ Cold ❑ Sweet ❑ Pressure		
Do you have any pain when you chew?	❑	❑
Have you experienced any pain in the muscles of your face or ear?	❑	❑
Do you have frequent headaches, neck aches or shoulder aches?	❑	❑
Did you ever have any blows to your jaw?	❑	❑
Does your jaw crack or pop?	❑	❑
Does your jaw lock when open or closed?	❑	❑
Do you chew primarily on one side of the mouth?	❑	❑
Does food catch between your teeth?	❑	❑
Do you feel any of your fillings?	❑	❑
Do you breathe through your mouth when sleeping?	❑	❑
Have you been given oral hygiene instructions?	❑	❑
Are you happy with the appearance of your teeth?	❑	❑

DOCTOR'S COMMENTS

Do any of the following problems apply to you?

❑ Painful Gums
❑ Swollen Gums
❑ Grinding/Clenching
❑ Nail/Pen Biting
❑ Mouth Growths
❑ Gag Easily
❑ Tooth Ache/Pain
❑ Loose Teeth
❑ Lip/Cheek Biting
❑ Mouth Sores
❑ Bad Breath
❑ Broken Teeth

Check any of the following that me be of interest to you:

❑ Braces
❑ Closing Spaces Between Teeth
❑ Replacing Missing Teeth
❑ Repairing Chipped Teeth
❑ Improve Gum Health
❑ Improving Your Smile
❑ Straightening Your Teeth
❑ Improving Bite
❑ Caps (Crowns)
❑ Whitening Teeth
❑ Improving Breath Odor
❑ Other _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient or Parent/Guardian Signature: _____ Date: _____

Treating Dentist's Signature: _____ Date: _____

DENTISTRY AT
Lifestyles

CHILD MEDICAL/DENTAL HISTORY

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?	❑	❑
Is your child presently receiving medical treatment?	❑	❑
Is your child presently taking medication?	❑	❑
Has your child ever been hospitalized?	❑	❑
Does your child have a history or allergies, sensitivities or adverse reactions to any drugs/medications/substances?	❑	❑

DOCTOR'S COMMENTS

_____

_____

_____

Has your child ever had any of the following conditions?

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

DENTAL HISTORY

	YES	NO
Is this your child's first visit to a dentist?	❑	❑
Has your child ever had a mouth injury?	❑	❑
Has your child ever had orthodontics?	❑	❑
Does your child have any of the following habits?		
Thumb Sucking	❑	❑
Lip Biting	❑	❑
Nail Biting	❑	❑
Mouth Breathing	❑	❑
Jaw Clenching	❑	❑
Teeth Grinding	❑	❑
Tongue Thrusting	❑	❑
Chew Hard Objects	❑	❑
Has your child ever received a local anesthetic?	❑	❑
Has your child had difficulty with previous dental visits?	❑	❑

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 or 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