Allandale
DENTAL CENTRE

Patient Intake

New

Dr. Amanda Bray | 274 Burton Avenue • Barrie, ON L4N-5W4
(705)722-7600
info@barriedentists.com

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth: _____ Gender: _____

Address: _____ Apt./Unit #: _____

Province: _____ Postal Code: _____

Cellphone Number: _____ Home Number: _____

Work Number: _____ Ext: _____ Employer: _____

Email Address: _____

Emergency Contact – Please Notify (name & number): _____

May we send you email/text notifications? ☐ Yes ☐ No

Primary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____

Policy Holder Contact Phone Number: _____ (if different from above)

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Marital Status: ☐ Single ☐ Married/Common Law ☐ Other

Insurance Company Name: _____

Secondary Insurance Company Information

Name of Insurance Policy Holder: _____ Date of Birth: _____

Policy Holder Contact Phone Number: _____ (if different from above)

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Insurance Company Name: _____

Authorization

To the best of my knowledge, all of the preceding information is true and correct.
If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Responsible Party Name: _____ Signature: _____

Patient Name (please print): _____ Signature: _____ Date: _____

Medical History & Physician Information

Health Card Number: _____

Family Physician's Name: _____ Physician's Phone Number: _____

Preferred Pharmacy: _____ Pharmacy Phone Number: _____

Please check any of the following that apply to your health status:

☐ Heart Condition	☐ General Anesthetic Complications	☐ Kidney Disease	☐ Arthritis
☐ Heart Attack	☐ Diabetes Type 1 or 2	☐ Liver Disease	☐ Above Average Weight Gain/Loss
☐ Heart Murmur	☐ Hypoglycemia	☐ Asthma	☐ Osteoporosis
☐ Heart Surgery/Procedures	☐ HIV Positive/Aids	☐ Respiratory Conditions	☐ Long-term Actonel/Fosamax Use
☐ Angina	☐ Anemia	☐ Tuberculosis	☐ Vision Impairment
☐ Mitral Valve Prolapse	☐ Blood Disorders	☐ Snoring/Sleep Apnea	☐ Hearing Impairment
☐ Congenital Heart Disease	☐ Hepatitis A/B/C	☐ Dizziness/Fainting	☐ Physical Impairment
☐ Pacemaker	☐ Hemophilia	☐ HPV	☐ Cognitive Impairment
☐ Shortness of Breath	☐ Excessive Bleeding/Bruising	☐ Herpes/Cold Sores	☐ TMJ (jaw joint) Concerns
☐ Stroke	☐ Immune Deficiencies	☐ Stomach Ulcers	☐ Epilepsy/Seizures
☐ Infective Endocarditis	☐ Eating Disorder	☐ Acid Reflux	☐ Depression
☐ High Blood Pressure	☐ Lupus	☐ Intestinal/Stomach Problems	☐ Anxiety
☐ Low Blood Pressure	☐ Thyroid Disease	☐ Lung Disease	☐ Mental Health Issues
☐ Drug/Alcohol/Tobacco Dependency	☐ Steroid Therapy	☐ Joint Replacement Joint: _____ Date: _____	☐ Cancer Type: _____ Date: _____
			Radiation: _____
			Chemotherapy: _____
			Surgery: _____

Do you have any allergies or sensitivities to medications: _____

Food/Environment: _____

Has your family physician ever told you to take antibiotics/pre-med prior to dental procedures? ☐ Yes ☐ No

Have you ever experienced complications following any medical or dental procedures? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No ☐ Possibly If yes, How many weeks? _____ weeks.

Are you taking any medications? ☐ Yes ☐ No

If yes, please specify which medications: _____

Is there anything else that you think we should be aware of regarding your medical status? ☐ Yes ☐ No

If yes, please describe: _____

Patient (please print): _____ Signature: _____ Date: _____

☐ Patient ☐ Parent ☐ Guardian ☐ Patient ☐ Parent ☐ Guardian

Dentist (please print): _____ Signature: _____ Date: _____

Dental History

Name of previous dental clinic and phone number: _____

Date of most recent dental visit (x-rays & hygiene): _____

I routinely see my dentist every: ☐ 3 Months ☐ 4 Months ☐ 6 Months ☐ 9 Months ☐ 12 Months ☐ Not Routinely

How frequently do you brush your teeth? ☐ Once per day ☐ Twice per day ☐ Three times per day

How frequently do you floss? ☐ Once per day ☐ Twice per day ☐ A couple times weekly ☐ Never

Do your gums bleed while brushing or flossing? ☐ Yes ☐ No

Are any of your teeth sensitive to heat, cold, sweets or pressure? ☐ Yes ☐ No

What is the most important thing to you about your visit today? _____

What is the most important thing to you about your future smile and dental health? _____

Do you have any fear/anxiety of dental treatment? ☐ Yes ☐ No

Is there anything about your dental appearance that you would like to improve or change?

_____

Have you ever whitened your teeth? (at home or professionally) ☐ Yes ☐ No If yes, which kind? _____

Are you self conscious about your smile? ☐ Yes ☐ No If yes, please describe: _____

Have you ever experienced any of the following jaw problems:

Popping or clicking in your jaw joints? ☐ Yes ☐ No

Pain in your jaw joints around your ear or side of your face? ☐ Yes ☐ No

Difficulty opening or closing? ☐ Yes ☐ No

Pain when teeth are clenched? ☐ Yes ☐ No

Pain or difficulty while chewing? ☐ Yes ☐ No

Do you have any of the following habits:

Clenching or grinding your teeth while awake or asleep? ☐ Yes ☐ No

Biting the inside of your cheeks or lips? ☐ Yes ☐ No

Mouth breathing while awake or asleep? ☐ Yes ☐ No

Placing foreign objects in your mouth (pencils, pens, fingernails)? ☐ Yes ☐ No

How do hear about us?

☐ Google/Internet

☐ Signage

☐ Instagram

☐ Facebook

☐ Friend/Family – Please let us know who refer you so we can thank them! _____

☐ Other/Outside Referral – Please specify: _____

Signature: _____ Date: _____

PATIENT CONSENT FORM: COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Privacy of your personal health information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients. In this office. Dr. Amanda Bray is the contact person for personal health information related matters. All staff members who come in contact with your personal health 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. We have given you an outline of what our office is doing to ensure that: (PLEASE SEE HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL HEALTH INFOMATION FORM PROVIDED TO YOU) -only necessary information is collected about you; -we only share your information with your consent; -storage, retention and destruction of your personal health information complies with existing legislation, and privacy protection protocols; -our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purposes that are listed. If a new purpose arises for the use and/ or disclosure of your personal health information, we will seek your approval in advance. Your personal health information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA. You may withdraw your consent for use or disclosure of your personal health information at any time.

Patient Consent

I have reviewed the information that explains how your office will use my personal health information, and the steps your office is taking to protect my information. I agree that Allandale Dental Centre can collect, use and disclose personal health information about me as set out in the information provided to me about the office's privacy policies.

Signature: _____ Date: _____

Cancellation Policy

The goal of Allandale Dental Centre is to serve the needs of ALL patients. We require a minimum of two (2) business days notice for any changes to your scheduled appointment in order for no charges to apply. if we are not given the minimum two (2) business days requirement, a $50.00 fee will be applied to your account. This also applies if no notice is given or if you do not show up for your scheduled appointment. Please note insurance companies **DO NOT** cover fees for broken appointments. The fee will be the responsibility of the patient and any future appointments, will no longer be held or booked respectively, until the applied fee has been paid. If you have any questions regarding this policy, please note any one of our team members will be more than happy to answer any questions you may have.

I acknowledge that I have read this statement and agree to the contents within.

Signature: _____ Date: _____