Dentistry AT VITALITY HEALTH | THE COMPLETE SPECTRUM OF SERVICES

Welcome to Vitality!

The following documents are the confidential property of the patient listed below, and as such, are subject to the standards and regulations of Canada's *Personal Information Protection and Electronic Documents Act (PIPEDA)*.

At Dentistry at Vitality Health, our Privacy Policy respects the patient's right to privacy. Therefore, we take specific measures to ensure that all the information provided to us by a patient is collected, handled, stored and utilized in a manner that maintains confidentiality. We do not sell or pass on such information to parties not involved in assisting us in providing services to you.

Information provided to us must be utilized for the specific purpose of providing our patients with the best possible dental and health treatments. We request that you sign the consent below which permits us to collect, use and disclose your personal information for the purposes listed below:

- Patient contact and communication of any kind;
- Assessment of patient health, and subsequent diagnosis, planning, treatment, evaluation and future follow-up;
- Disclosure of information to insurance companies, labs and necessary suppliers;
- For the purpose of invoicing for goods and services;
- Compliance with regulatory and legal authorities;
- Communication with other healthcare providers as deemed necessary and in the best interest of the patient;
- To process credit card transactions;
- To collect unpaid and/or outstanding accounts;
- To comply with the legislation as it relates to the Healthcare Professions Act of Ontario.

Should you wish to withdraw your consent, or review your personal information, you may do so at any time by contacting our Privacy Officer. If withdrawing your consent has any impact on the services we provide you, our Privacy Officer will draw your attention to these consequences and ask you to confirm your decision to continue.

I have read and understand the Privacy Policy above, and agree to give my consent for Dentistry at Vitality Health *to collect, use and disclose my personal information for the purposes listed. Should an unusual request be received, it is understood that* Dentistry at Vitality Health *will contact me for permission to release such information as is necessary and/or appropriate.*

_____ _____

Signature *Print Name*

_____ _____

Date *Witness*

Last Name:_____

First Name:_____

Today's Date:_____ **D.O.B.:**_____

DD/MM/YYYY *DD/MM/YYYY*

MEDICAL ALERT
Office Use Only

PERSONAL INFORMATION			**Gender:**	**Male Female Prefer not to say**
Pref. Name:			**Salutation:**	**Mr. Ms. Mrs. Mstr. Miss Dr.**
Address (Home)			**Apt. #:**	
City:		**Prov.:**	**Postal Code**	
Home #:	**( ) -**		**E-mail:**	
Cell #:	**( ) -**		**Confirm Pref: Text Email H# W# C#**	
Work #:	**( ) -**		**Occupation:**	
Address (Work)			**How did you find out about our office?**	

EMERGENCY CONTACT INFORMATION		**RELATIONSHIP**		
Name 1:			**Telephone:**	**( ) -**
Name 2:			**Telephone:**	**( ) -**
FAMILY PHYSICIAN INFORMATION				
Name:			**Telephone:**	**( ) -**
Address:			**Fax:**	**( ) -**
City/Prov.:			**Postal Code:**	

NAME OF MEDICAL SPECIALISTS *Please complete if applicable*		
Area of Speciality		**Telephone: ( ) -**
Area of Speciality		**Telephone: ( ) -**

ACCOUNT HOLDER INFORMATION *Please complete if different from above.*		**Home #:**	**( ) -**
Name:		**Cell #:**	**( ) -**
Address:		**Apt. #:**	
City/Prov.:		**Postal Code:**	
Employer:		**Relationship:**	
PRIMARY INSURANCE INFORMATION *(If applicable)*			
Ins Co.:		**Insured D.O.B.**	
Policy #:		**Relationship:**	
I.D. #:		**Telephone:**	**( ) -**
Insured:		**Employer:**	
SECONDARY INSURANCE INFORMATION *(If applicable)*			
Ins. Co.:		**Insured D.O.B.**	
Policy #:		**Relationship:**	
I.D. #:		**Telephone:**	**( ) -**
Insured:		**Employer:**	

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

	MEDICAL HEALTH INFORMATION	NO	YES	*If YES, specify & include Medication*
1	*When was your last medical checkup?*			
2	*Are you currently being treated for any medical condition, or have you been treated within the past year?*			
3	*Has there been any change in your general health in the past year?*			
4	*Are you taking any prescription drugs, medications, (including the birth control pill)? If yes, please list them and include the dosage/s?*			
5	*Are you taking any O.T.C. (over-the-counter) medications/ non-prescription drugs or herbal supplements of any kind? If yes, please list them*			
6	*Have you ever had a peculiar, adverse or unusual reaction to any medicines, local anesthetic or injections of any kind?*			
7	*Do you have any allergies to medications?*			
8	*Do you have any allergies to latex or rubber products?*			
9	*Do you have any other known allergies or adverse reactions? (e.g., hay fever, seasonal/environmental, foods).*			
10	*Do you have, or have you ever had, any heart or cardiovascular condition, a repair or replacement of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease), a heart murmur (mitral valve prolapse), or a heart transplant or any cardiac condition, and if so, was antibiotic prophylaxis recommended?*			
11	*Do you have, or have you ever had, Diabetes Mellitus (DM)*			
12	*Do you have a bleeding problem or a bleeding / blood disorder?*			
13	*Have you ever been hospitalized for any illness or operations?*			
14	*Do you have, or have you ever had, any hypertension or blood pressure problems?*			
15	*Do you have any other condition for which antibiotic prophylaxis is recommended or required?*			
16	*Do you have, or have you ever had, any immunocompromising conditions, or are undergoing therapies, which affect your immune system? (eg. Leukemia, AIDS, HIV infection, chemotherapy, or radiotherapy)*			
17	*Do you have a prosthetic or artificial joint?*			
18	*Do you have, or have you ever had, asthma or breathing problems?*			
19	*Do you have, or have you ever had, hepatitis, jaundice, or liver disease?*			
20	*Are there any illnesses, diseases or medical problems that run in your family? (e.g. Cancer, diabetes, heart disease)*			
21	*Do you smoke or chew tobacco products, or use tobacco/ Vape products?*			

Do you have, or have you ever had, any of the following conditions?

CONDITION	NO	YES	CONDITION	NO	YES
Anemia			*Pacemaker*		
Arthritis			*Psychiatric Problems*		
Blood Transfusion			*Rheumatic Fever or Scarlet Fever*		
Cancer			*Severe or Frequent Headaches*		
Chest pain, angina			*Shingles*		
Dementia			*Shortness of breath*		

CONDITION	NO	YES	CONDITION	NO	YES
Drug, Alcohol, Cannabis use or Substance Abuse			*Sickle Cell Disease or Traits*		
Emphysema			*Sinus Problems*		
Epilepsy, Seizures or Fainting Spells			*Steroid therapy*		
Fever Blisters or Cold Sores			*Stomach ulcers, Colitis or Other G.I. Conditions*		
Heart attack			*Stroke, TIA*		
Kidney Problems			*Thyroid disease*		
Lung disease			*Tuberculosis (TB)*		
Osteoporosis medications (e.g.Fosamax, Actonel)			*Venereal Disease*		

Are you Pregnant? If pregnant, what is the expected delivery date?	**No**	**Yes**
Are you breastfeeding?	**No**	**Yes**
Do you identify yourself as a patient with a disability? If yes, please explain.	**No**	**Yes**
Are there any conditions or diseases not listed above that you have or have had? If yes, please explain:	**No**	**Yes**

DENTAL HEALTH INFORMATION and Todays Visit. ***Please fill in the details in the space provided. (For new patients only)***

Chief Concern/Complaint: What is the reason for your visit today? Are you currently experiencing any dental problems? :		
When was your last dental visit, and what was done at that appointment?		
When did you last have dental x-rays?		
How would you describe your previous dental experiences?		
How often do you brush per day? *How often do you floss?*		
Do your gums bleed when you brush or floss?	**No**	**Yes**
Have you been seeing a dentist and/or dental hygienist regularly? If not, why not?	**No**	**Yes**
Are you nervous during dental visits and treatment?	**No**	**Yes**
Have you had a bad experiences or complications during dental treatment?	**No**	**Yes**
Have you ever seen a dental specialist?	**No**	**Yes**
Have you ever been advised to take antibiotics prior to dental treatment?	**No**	**Yes**
Do you feel that you have bad breath?	**No**	**Yes**
Are you happy with your smile or the appearance of your teeth?	**No**	**Yes**
Do you have any problems with your jaw (pain, clicking, limited movement) or tension in the muscles of your face?	**No**	**Yes**
Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?	**No**	**Yes**
Do you feel that your diet is adequate and balanced?	**No**	**Yes**

I hereby state that the information above is correct and complete to the best of my knowledge.

Signature of Patient / Parent / Guardian ***Date*** *DD/MM/YYYY*

Signature of Practitioner ***Date*** *DD/MM/YYYY*

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Office Policy

At Dentistry at Vitality Health we do our outmost to ensure that you are seen by the dental clinician in a timely manner. Your appointment time is reserved especially for you. If you are unable to keep your appointment we ask that you inform us two (2) business days prior to the time of your scheduled appointment. We understand that there may be times when unforeseen circumstances will prevent you from making your appointment time. We ask that you respect our office policy in any case and notify us as soon as possible in these particular situations.

As such we are obligated to inform you that there **is A CHARGE OF $100 for a missed or cancelled appointment that does not meet the required notification time mentioned above.**

Our office implements a fee for service policy, which means that any treatments and or procedures received are paid immediately after they are performed. In certain circumstances, a consultation may be scheduled with one of our administrators to coordinate a payment schedule and/or to facilitate account payment.

Please indicate below which of the following is your preferred payment method(s) by placing a check in the applicable box:

- ☐ Cash or Direct Payment
- ☐ Credit Card (Visa, MasterCard)

Please note that overdue accounts are subject to a 2% monthly interest charge and that the patient/account holder is responsible for any NSF cheque charges or any collection fees incurred in the process of collecting any outstanding debts

Name of person responsible for account: _____

Relationship to patient : _____

_____ Signature of Account Holder

_____ Date