208 King Street South,
Waterloo ON N2J 1P9

PATIENT REGISTRATION

The information that is requested on this questionnaire is essential to providing you with the highest standard of dental care.

MEDICAL ALERT ○ Yes ○ No

DATE: 01/29/2018

Patient Information

First Name:

Last Name:

Date of Birth: 01/29/2018

Email:

Mobile #:

Home Phone #:

Work Phone # (include ext):

Preferred Phone: ○ Mobile ○ Home ○ Work

○ Male ○ Female

○ Adult ○ Child ○ Student
○ Adult under Guardianship

Name of Guardian:

Guardian Phone:

○ Single ○ Married ○ Other

Name of Spouse:

Address Line 1:

Address Line 2:

City:

Province:

Postal Code:

MEDICAL ALERT

Condition:

Premedication:

Family Physician:

Address:

Physician Phone #:

Medical Specialist:

We invite you to participate in our online System:

- Request Appointments Online
- Confirm Appointments Online
- Receive Text Message Appt. reminder

Email:
○ Opt In ○ Opt Out

Email Address:

Text Message:
○ Opt In ○ Opt Out

Cell Phone Number:

In case of Emergency, Please contact: Phone #:

Whom may we thank for referring you:

How did you hear about us:

FINANCIAL INFORMATION:

This information is necessary to process invoice and apply payments.

Person responsible for account:
○ Self ○ Spouse ○ Other

PRIMARY DENTAL INSURANCE:

Max Coverage:
Subscriber's Name:
Date of Birth: 01/29/2018
Employer / Group Policy Holder:
Insurance Year End:
Insurance Company:
Telephone:
Group / Insurance Policy Number:
Certificate Number:
I.D. (Driver's License):
% Coverage Basic: Major Restoration:
Ortho: Other:

SECONDARY DENTAL INSURANCE:

Max Coverage:
Subscriber's Name:
Date of Birth: 01/29/2018
Employer / Group Policy Holder:
Insurance Year End:
Insurance Company:
Telephone:
Group / Insurance Policy Number:
Certificate Number:
I.D. (Driver's License):
% Coverage Basic: Major Restoration:
Ortho: Other:

DENTAL HISTORY:

Please check Yes or No to Each Question. If unsure of a question, please consult with the Dentist.

Is there a dental problem you would like treated immediately? ○ Yes ○ No
Date of your last visit? 01/29/2018 Last Dental cleaning? 01/29/2018 Last X-Rays? 01/29/2018

1.	Have you been seeing a dentist regularly?	○ Yes ○ No
2.	Why did you leave your last dentist?	
3.	Have you ever had any of the following?	
	Periodontal Treatment? (Treatment of the gums)	○ Yes ○ No
	Orthodontic Treatment? (to straighten or realign teeth)	○ Yes ○ No

	A bite plate or any other appliance	○ Yes ○ No
	Oral Surgery? (surgery in or about the mouth/Jaw joint or implant surgery in on or both of you jaw joints?	○ Yes ○ No
	If you answered “Yes” to the last question, who performed the surgery? When?	
	Are you being followed up by a dental specialist?	○ Yes ○ No
4.	Are there any growths or sore spots/swelling in your mouth?	○ Yes ○ No
5.	Do your gums bleed when brushing or eating, or do you suffer from pain or swelling of your gums?	○ Yes ○ No
6.	Have you noticed any loose teeth or have any of your teeth shifted?	○ Yes ○ No
7.	Does food catch between your teeth?	○ Yes ○ No
8.	Are any of your teeth sensitive to heat, cold, sweets or pressure?	○ Yes ○ No
9.	Have you been advised to take antibiotics before a dental Appointment?	○ Yes ○ No
10.	Do you use dental floss, proxabrush or stimudents? How often?	○ Yes ○ No
11.	How often do you brush your teeth?	
12.	Do you feel that you have bad breath?	○ Yes ○ No
13.	Have you ever experienced any of the following jaw problems:	
	Popping / Clicking in your jaw joints?	○ Yes ○ No
	Difficulty in opening or closing?	○ Yes ○ No
	Pain when teeth are clenched?	○ Yes ○ No
	Pain or difficulty while chewing?	○ Yes ○ No
14.	Do you have any of the following habits?	
	Clenching or grinding your teeth while awake or asleep?	○ Yes ○ No
	Do you bite your cheek or lip?	○ Yes ○ No
	Mouth breathing while awake or asleep?	○ Yes ○ No
	Placing foreign objects in your mouth (Pencils, nails, pipes, pins, fingernails)?	○ Yes ○ No
15.	Do you have any emotional concerns about having dental treatment?	○ Yes ○ No
16.	Have you ever had an upsetting experience in a dental office or any complication during or following dental treatment or do you have any questions or concerns?	○ Yes ○ No
17.	Do you feel your dental health influences your overall health?	○ Yes ○ No
18.	On a scale of 1 – 10, 10 being highest, how important is it for you to keep your natural teeth?	
19.	Do you currently wear a bite guard at night?	○ Yes ○ No

MEDICAL HISTORY:

Please check Yes or No to Each Question. If unsure of a question, please consult with the Dentist.

1.	Are you being treated for any medical condition at present or within the past five years?	○ Yes ○ No
	If Yes, Please Explain:	
	Physician: Phone #:	
2.	Have you been hospitalized in the past two years?	○ Yes ○ No
3.	When was your last visit to a physician?	
4.	Last Complete Physical examination?	
5.	Have you recently or are you presently taking any prescription or non-prescription drugs including herbal remedies?	○ Yes ○ No
	Please list if you answered Yes above: If you need more that 6 areas for the list of medicines, please provide a copy at your first visit. 1: 2:	

3:
4:
5:
6:

6. Have you ever reacted adversely to any medications or injections? ○ Yes ○ No

Please Check :

- ☐ Penicillin or other antibiotics,
- ☐ Aspirin,
- ☐ Codeine,
- ☐ Local Anesthetic (Freezing),
- ☐ Nitrous Oxide,
- ☐ Any Other Medicines:

7. Have you been advised against taking any specific medication? ○ Yes ○ No

8. Do you have any of the following?

- ☐ Asthma,
- ☐ Hay Fever,
- ☐ Fever,
- ☐ Food Allergies,
- ☐ Mental disorders,
- ☐ Latex Allergies,
- ☐ Skin rashes,
- ☐ Hives,
- ☐ Any other Allergic conditions:

9. Do any of these allergic conditions result in headache,
Nausea, Swelling, Shortness of breath or Chest Constriction? ○ Yes ○ No

If so, please explain:

10 Is there a family history of

- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease

11.	Do you bleed Excessively from acute or Injury or Bruise easily?	○ Yes ○ No
12.	Do your ankles, feet or hands swell?	○ Yes ○ No
13.	Has your weight, appetite or energy level changed dramatically recently?	○ Yes ○ No
14	Are you following a special diet or are you on a diet pill therapy?	○ Yes ○ No
15.	Have you tested HIV positive?	○ Yes ○ No
16.	Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	○ Yes ○ No
17.	Do you have frequent severe headaches, earaches, ear/throat infections?	○ Yes ○ No
18.	Have you ever had any injury or surgery to your face or jaws?	○ Yes ○ No
19.	Do you wear eyeglasses or Contact lenses	○ Yes ○ No
20.	Do you have any hearing difficulties?	○ Yes ○ No
21.	Do you smoke or use any other forms of tobacco?	○ Yes ○ No
22.	Do you drink Alcohol? If so How much?	○ Yes ○ No
23	Are you Alcohol and / or drug dependent?	○ Yes ○ No
	If yes, have you received treatment?	○ Yes ○ No

24. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

Condition	Yes	No
A.I.D.S	○ Yes	○ No
Anemia	○ Yes	○ No
Angina Pectoris	○ Yes	○ No
Arthritis/rheumatism/Gout	○ Yes	○ No
Artificial heart valve	○ Yes	○ No
Artificial joints (hip, knee)	○ Yes	○ No
Blood Disorders	○ Yes	○ No
Bronchitis	○ Yes	○ No
Cancer/Tumors	○ Yes	○ No
Circulation Problems	○ Yes	○ No
Congenital Heart Lesions	○ Yes	○ No
Cortisone/steroid	○ Yes	○ No
Crohn's Disease	○ Yes	○ No
Diabetes	○ Yes	○ No
Emphysema	○ Yes	○ No
Epilepsy or seizures	○ Yes	○ No
Fainting or dizzy spells	○ Yes	○ No
Glandular Disorders	○ Yes	○ No
Glaucoma	○ Yes	○ No
Head/Neck Injuries	○ Yes	○ No
Heart Disease or Attack	○ Yes	○ No
Heart Murmur	○ Yes	○ No
Heart Pacemaker	○ Yes	○ No
Heart Rhythm Disorder	○ Yes	○ No
Heart Surgery/Chest Pains	○ Yes	○ No
Hepatitis A B C	○ Yes	○ No
Herpes	○ Yes	○ No
High/Low Blood Pressure	○ Yes	○ No
Hodgkin's Disease	○ Yes	○ No
Hyper (Hypo) Glycemia	○ Yes	○ No
Hypertension	○ Yes	○ No
Inflammatory Bowel Disease	○ Yes	○ No
Jaundice	○ Yes	○ No
Kidney Disease	○ Yes	○ No
Liver Disease	○ Yes	○ No
Lung Disease	○ Yes	○ No
Lupus	○ Yes	○ No
Malignant Hyperthermia	○ Yes	○ No
Mental/nervous disorder	○ Yes	○ No
Mitral valve prolapse	○ Yes	○ No
Organ transplant/medical implant	○ Yes	○ No
Psychiatric Treatment	○ Yes	○ No
Radiation treatment/chemotherapy	○ Yes	○ No
Scarlet fever ---Rheumatic fever	○ Yes	○ No
Sickle cell disease	○ Yes	○ No
Sinus trouble	○ Yes	○ No
Stomach/Intestinal problems/Ulcers	○ Yes	○ No
Stroke/Paralysis	○ Yes	○ No
Thyroid Disease	○ Yes	○ No

Tuberculosis	○ Yes ○ No
Venereal Disease	○ Yes ○ No
Surgery in hospital	○ Yes ○ No
Steroid Therapy	○ Yes ○ No
Other:	○ Yes ○ No

I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I have been advised of the privacy policy of the office and that personal information will be collected, used and disclosed with the guidelines of the policy. I authorize release, to my insurance company / plan administrator, the information contained in claims electronically and for direct assignment to the dental office, if applicable. I understand that responsibility for payment of the dental service for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

I, the undersigned certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical and dental history. Should there be any change in my health status in the future, I will advise King Street Dental Centre.

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Signature

Date: 01/29/2018

○ Patient ○ Parent ○ Guardian

Name of Guardian:

FINANCIAL POLICY

Insurance: As a courtesy to all our patients we will verify your dental insurance benefits, but you are responsible to know your plan coverage, exclusions and limitations, furthermore, you should be aware of non-covered benefits such as missing teeth, specific exams, prophylaxis, fluoride, x-rays etc. The estimated amount not covered by your insurance is due at the time of treatment payment may be paid by Cash, Visa, Mastercard, or Debit. To help you accept an extensive treatment plan, we are offering financing on extensive treatments. All estimates are subject to final approval by your dental insurance plan, therefore the amount due is subject change after final explanation of benefits have been paid.
Initial:

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Initial

Initial Payment for Dental Treatment: Most plans are covered for routine clinical exam and cleaning and no deductible is due for diagnostic or preventative treatment unless otherwise stated. There are some plans with co-insurance payments for x-rays and dental exams. Deductible for basic and / or major services customarily include fillings, crowns extractions, root canal therapy and periodontal treatment. Deductibles are usually $50 - $100 per individual or $200 per family annually. 10% - 20% Co-payment for all basic services For any build-up & crown procedure, most plans do not allow separate benefits for crown build-up. In such a case the patient is responsible for the full cost of a build-up. The lab fee is an additional cost. It can also be offered to you as an optional for restorations requiring specific materials or advanced techniques. (Bruxism appliances (Night Guards), Veneers, all porcelain crowns, porcelain margins, etc.) You will be advised on any additional lab cost prior to the start of treatment.

Resin- Based Composite Restorations (Fillings): Most dental insurance plans do not allow full benefits for composites (White fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for less expensive treatment, such as Amalgam (silver / mercury based restoration). For the best of our patients, we recommend and we place only

composite-based (“white”) fillings. The difference is usually $50 - $70 per filling and the patient is responsible for the difference in cost. Please ask our front desk or doctor if you need more information about Composite-based fillings.
Initial:

Initial

Missed Appointment Fee: Please note that there is a missed appointment fee of $35 for all missed appointments not given at least 24 hours (Business hours) in advance. Please give us a call in advance if you need to reschedule or cancel your appointment.

Transferring Records: You will need to request in writing if you would like us to mail, fax, email, etc. your dental records with Dr. A Reddy. We need at least 8 working hours in advance to prepare your record to be transferred.

Past Due Accounts: In the event that your account is turned over to a collection agency or attorney, you agree to pay all fees including and not limited to attorney fees, court fees and collection agency fees.

This is an agreement between Dr. A Reddy, as a provider of professional services and creditor with the patient, debtor named on this form. By reading and signing this agreement, you are agreeing and accepting this policy in full.

I have read and understand the above information, all my questions were answered to my satisfaction, I understand and agree to all policies of King Street Dental Centre.

Signature

Date: 01/29/2018 Name:

COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. This office will collect, use and disclose information about you for the following purposes:

- To enable us to contact you (your child) and to book and confirm appointments
- To advise you of treatment options
- To communicate with other health care providers, including medical and dental specialist and general practitioners
- To comply with legal and regulatory requirements, including the delivery of patients charts and records to Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulatory Health Professions Act
- To comply with agreement / undertakings entered into voluntarily by Dr. A Reddy with the Royal College of Dental Surgeons of Ontario, including the delivery and / or review of patients charts and records to college in a timely fashion for the regulatory and monitoring purposes
- To prepare material for the Health Professions Appeal and Review Board
- To process credit card payments
- To collect unpaid accounts

We also use this information to provide you with excellent treatment. We may disclose patient Health Information (PHI) to third parties that perform services for King Street Dental Centre in the administration of your benefits in accordance with HIPAA and / or PIPEDA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. You PHI may be disclosed to an affiliate that performs services for King Street Dental Centre in the administration of your benefits. Our affiliated do not sell, share or rent our users personally identifiable information unless required by law, do not send any email or other

communications without user permission and do not send spam.

I have reviewed the above information that explains how your office will use my personal information. I agree that Dr. A Reddy can collect, use and disclose personal information as set out above in the information about the office's privacy policies according to the requirements of the Regulated Health Professions Act, the Royal College of Dental Surgeons and privacy legislation:

Signature

Date: 01/29/2018 Name:

Dr. A Reddy
King Street Dental Centre
208 King Street South
Waterloo ON N2J 1P9

Signature