

PATIENT REGISTRATION			
The patient is an: ADULT CHILD ADULT UNDER GUARDIANSHIP			
Name of Guardian:			
Last Name: First Name: Middle Initial:			
Preferred Name: DR. MR. MRS. MISS MS			
Date of Birth (Month/Day/Year): Female Male X			
Address:			
City: Province: Postal Code:			
Home # ( ) Cell # ( ) Work # ( )			
May we call you at work? Yes No			
Who may we thank for referring you to our office?			
FAMILY DOCTOR & EMERGENCY CONTACT INFORMATION			
Family Physician: Phone: ( )			
Emergency Contact: Phone: ( )			
Alternate Contact: Phone: ( )			
SCHEDULED APPOINTMENTS			
Please know that scheduled appointments times have been reserved especially for you, and that any change in the schedule			
affects many people. If for any reason you are unable to keep the reserved appointment time, we ask the courtesy of 24-48			
hours notice to allow us to offer the time to another patient who may be waiting.			
The first time there is a missed appointment you will simply be reminded about this policy. The second time, a letter alerting			
you to the fact that you have failed to show up for a second time and did not cancel the appointment in a timely manner will be			
sent (a copy will be placed in your patient file). The third time you fail to attend a scheduled appointment and/or cancel without			
appropriate notice will result in a charge of \$50. This charge will be donated to the Grey Bruce Regional Health Centre. Chronic			
short notice cancellations or failure to show up for appointments will result in dismissal from our office.			
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Signature: Date:			
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Are there any conditions or diseases not listed above that you have or have had?  f yes, Please list:  Have you ever had a peculiar or adverse reaction to any of the following medications? (Please circle): Penicillin, Tetracy builfa, Erythromycin, Aspirin, Barbiturates (sleeping pills), Codeine, Darvon, Local Anesthetic (freezing), Epinephrine, Nitro Divide, or any other medications:  f yes, please explain:  Do you have allergies to latex/rubber products?  Do you have any other allergies not listed above?  f yes, please list:  Have you ever been hospitalized for any illnesses or operations?  f yes, please explain:  Have you being treated for any medical condition at the present, or have you been treated within the past year?  f yes, please explain:  Has there been any change in your general health in the past year?  f yes, please explain:  Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections?  Has your weight, appetite, or energy level changed drastically recently?  Do you smoke or use any other forms of tobacco?  Cigarettes Cigars Pipe Other Other Number per day?: How many years?:  Are you alcohol and/or drug dependant?  f yes, have you received treatment?  Are you nervous during dental treatment?  CHILDREN ONLY  Weessles Mumps Chicken Pox  NOMEN ONLY  Are you pregnant or breastfeeding? If pregnant, when is the expected due date?		ion-prescription arugs, or nerbai supplen	ients of any kind?
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	Signature of patient (or parent/guardian)	Date		Signature of Dentist/Hygienist

## 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 below how our office is collecting, using and disclosing your personal information.

This office will collect, use, and disclose information about you for the following purposes:

- To assess your health needs and provide safe and efficient dental care.
- To enable us to contact and maintain communication with you to distribute health-care information and to book and confirm appointments.
- To communicate with other treating health-care providers, including other dentists, physicians, pharmacists and lab technicians.
- For teaching and demonstrating purposes on an anonymous basis.
- To complete and submit dental claims for third party adjudication and payments.
- To comply with legal and regulatory requirements.
- To deliver your charts and records to dentists' insurance carrier to enable to insurance company to assess liability and quantify damages as necessary.
- To invoice for goods and services, process credit card payments, and collect unpaid accounts.

Thank you for your support and	understanding in	helping our o	office to con	nply with al	l regulatory
requirements and generally with	າ the law.				

x				
	Signature of patient (or parent/guardian)	Date		

**East Ridge Family Dental** 

695 9<sup>™</sup> Avenue East

Owen Sound, ON N4K 3E4

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Fax: (519) 371-6569

reception@eastridgedental.ca