EAST RIDGE FAMILY
DENTAL

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.

Signature: _____ Date: _____

ONLINE APPOINTMENTS

We invite you to participate in email correspondence with our reception staff that allows patients to request appointments by email, receive appointment reminders by email and to confirm appointments by email.

I agree to provide my email address for contact purposes and understand I can revoke my consent at any time.

EMAIL: _____

Signature: _____ Date: _____

FEES/PAYMENTS

I understand and agree that this office, as a courtesy to me, will not impose any interest charges to any balance for a period of thirty days after the charges are incurred. It is understood that any balance outstanding for more than thirty days will be charged interest at the rate of 2% per month and I agree to pay said charges.

I understand and agree that my dental insurance policy is an arrangement between an insurance carrier and myself. This office will prepare and submit electronically any necessary reports and forms to assist me in getting reimbursed from the insurance company directly. However, all services rendered to myself, or to a minor patient/adult under guardianship, are charged directly to me and I am personally responsible for payment in full at the time of the appointment.

Signature: _____ Date: _____

HEALTH HISTORY: Please indicate which of the following you presently have or have ever had					
AIDS/HIV		Head/Neck Injuries		Mental/Nervous Disorder	
Anemia		Heart Disease or Attack		Mitral Valve Disorder	
Angina/Chest Pain		Heart Murmur		Organ Transplant	
Arthritis/Rheumatism		Heart Pacemaker		Psychiatric Treatment	
Artificial Heart Valve		Heart Rhythm Disorder		Radiation/Chemotherapy	
Artificial Joints		Heart Surgery		Rheumatic/Scarlet Fever	
Asthma		Hepatitis (A, B, C)		Shortness of Breath	
Bleed Excessively		Herpes		Sickle Cell Disease	
Blood Disorder		High/Low Blood Pressure		Sinus Trouble	
Bronchitis		Hodgkin's Disease		Stomach/Intestinal Issues	
Bruise Easily		Hyper/Hypo Gylcemia		Stroke	
Cancer		Jaundice		Swelling (hands/ankles, etc)	
Circulation Problems		Kidney Disease		Thyroid Disease	
Congenital Heart Lesions		Liver Disease		Tonsillitis or Strep Throat	
Cortisone/Steroid		Lung Disease		Tuberculosis	
Diabetes (Type I or Type II)		Malignant Hyperthermia		Ulcers	
Emphysema		Medical Implant		Venereal Disease	

ADDITIONAL HEALTH INFORMATION	
Are you taking any medications, non-prescription drugs, or herbal supplements of any kind?	
If yes, please list: _____ _____	
Are there any conditions or diseases not listed above that you have or have had?	
If yes, Please list:	
Have you ever had a peculiar or adverse reaction to any of the following medications? (Please circle): Penicillin, Tetracycline, Sulfa, Erythromycin, Aspirin, Barbiturates (sleeping pills), Codeine, Darvon, Local Anesthetic (freezing), Epinephrine, Nitrous Oxide, **or any other medications:**	
If yes, please explain:	
Do you have allergies to latex/rubber products?	
Do you have any other allergies not listed above?	
If yes, please list:	
Have you ever been hospitalized for any illnesses or operations?	
If yes, please explain:	
Are you being treated for any medical condition at the present, or have you been treated within the past year?	
If so, why?	
When was your last medical checkup?	
Has there been any change in your general health in the past year?	
If 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?	
If yes, have you received treatment?	
Are you nervous during dental treatment?	

CHILDREN ONLY					
Measles		Mumps		Chicken Pox	

WOMEN ONLY	
Are you pregnant or breastfeeding? If pregnant, when is the expected due date?	
Are you taking birth control pills?	

To the best of my knowledge, the above information is correct and I am aware the providing false information can be dangerous to my health.

X _____ _____ X _____

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 office to comply with all regulatory requirements and generally with the law.

X _____ _____

Signature of patient (or parent/guardian) Date

East Ridge Family Dental

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Fax: (519) 371-6569

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