ERINGATE DENTAL CLINIC

450 Rathburn Road, Toronto, Ontario M9C 3S6
(416) 695-9372 • eringatedental.com

Have Healthy Teeth and Gums for Life

Medical Alert: _____

PATIENT INFORMATION

Welcome to Our Dental Office!
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. Please fill in the entire form.

PERSONAL INFORMATION

Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Last Name: _____
First Name: _____ Mid: _____ Preferred Name: _____
Status: Single ☐ Married ☐ Child ☐ Other ☐ Date of Birth (DD/MM/YY): ____/____/____
Home Address: _____ Apt: _____
City: _____ Postal Code: _____
Email: _____ Home Tel: _____
Work Tel: _____ Cell: _____
Employer: _____ Occupation: _____
Physician: _____ Physician's Phone No: _____
Previous Dentist: _____
How long have you been a patient? _____ Months/Years
Why have you decided to change dental offices? _____
How did you hear about us? _____
Are you available for short notice? Yes ☐ No ☐
Best method of contact: Call ☐ Text ☐ Email ☐

INSURANCE INFORMATION 1

Name of insured: _____
Employer: _____ Date of Birth of Insured (DD/MM/YY): ____/____/____
Insurance Company: _____ Policy/Group: _____
Division (If applicable): _____ Certificate ID#: _____
Do you have Secondary Insurance? Yes ☐ No ☐ Are you familiar with your plan details? Yes ☐ No ☐
Relationship: Self ☐ Spouse ☐ Other ☐

INSURANCE INFORMATION 2

Name of insured if different from above: _____
Employer: _____ Date of Birth of Insured (DD/MM/YY): ____/____/____
Insurance Company: _____ Policy/Group: _____
Division (If applicable): _____ Certificate ID#: _____
Relationship: Self ☐ Spouse ☐ Other ☐ Are you familiar with your plan details? Yes ☐ No ☐

EMERGENCY CONTACT

Relationship: _____ Name _____
Tel: _____

CHILD MEDICAL HISTORY

First Name: _____ Last Name: _____

Child's Physician: _____ Phone: _____

Physician's Contact (Email or Tel): _____

Date of last visit: _____ Has your child had any serious illnesses or operations?

If yes, describe: _____

Is your child currently under physician care? ☐ Y ☐ N If yes, describe: _____

☐ Y ☐ N If yes, give approximate dates: _____

Has your child ever had a blood transfusion? _____

Check the corresponding box if your child has one or more of the following:

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Blood disease
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Convulsions/Epilepsy
- ☐ Cough persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart problems
- ☐ Describe:
- ☐ Hemophillia
- ☐ Abnormal Bleeding
- ☐ Immunizations current
- ☐ Kidney disease or malfunction
- ☐ Liver disease
- ☐ Material allergies
- ☐ (latex,wool,metal,chemicals)
- ☐ Respiratory disease
- ☐ Rhumatic/Scarlet fever
- ☐ Shortnes of breath
- ☐ Sinus problems
- ☐ Skin Rash
- ☐ Spina Bifida
- ☐ Thyroid disease or malfunction
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Other
- ☐ Describe:

List medications your child is taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

DENTAL HISTORY

What would you like us to do for your child today? _____

Former Dentist: _____ Address: _____

Dentist's Email: _____ Phone _____

Date of last dental care: _____ Date of last x-rays: _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? Y ☐ N ☐

Has your child ever experienced a mouth or chin injury? Y ☐ N ☐ Does your child have speech problems? Y ☐ N ☐

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y ☐ N ☐

Child's habits affecting the mouth or teeth: Thumb sucking ☐ Nail biting ☐ Other ☐ _____

Other information about your child's dental health or previous treatment: _____

_____

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

1. You will be asked about medical history, dental history, current and previous, chief complaint, and goals of the treatments. You will disclose the current accurate information to the best of your knowledge. This information will help us deliver safe and efficient dental care.
2. All fees are payable in full by the patient or parent/guardian at the time the service provided, we do not do direct billing. This means that your insurance cheque will go directly to you and not to you our office.
   If you provide us with your insurance information, we will be happy to submit the claims electronically on your behalf.
   For your convenience, we accept Visa, MasterCard or Debit.
3. All information you share is confidential, only necessary information is collected about you.
4. The doctor will only share your information with your consent.
5. Storage, retention and destruction of your personal information complies with existing legislation, and privacy. Privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons.
6. You have the right to deny use of any of our instruments. You have the right to ask all the questions about different procedures and getting them explained to you before they are conducted.
7. Collecting additional information such as, dental casts or impressions, x-ray or other means of imaging, photography, referral to other specialists such as and not limited to: Periodontists, Endodontists, Orthodontists, Oral Medicine, Oral Anesthesia, Maxillofacial Surgeon and Physician is needed to formulate accurate diagnoses and you will be informed about them as needed. You have the right to deny any of those data collection procedures.
8. You authorize photos and x-rays of your care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes. Your identity will not be revealed to the general public without your permission.

CANCELLATION

If an unforeseen circumstance occurs and you need to change your appointment, we require at least a **TWO (2) BUSINESS-DAY NOTICE.** A charge of $75 may apply, which will not be covered by your insurance.

I have read and understood the above statements. I agree that I am responsible for all dental charges due on the day of my dental treatment.

Please email **appointment@eringatedental.com** when completed

Print Name	Signature
Date	Signature of Witness