GEORGIAN MALL
DENTAL GROUP™
LIVBRITE

Orthodontist | Pediatric | Oral Surgeon | Endodontist | Periodontist | Prosthodontist

Adult Patient Consent Form

For collection, use and disclosure of personal information
Privacy of your personal information is an important part of our office, providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collection, using and disclosing your personal information.

All employees of Georgian Mall Dental Group who may come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. Our employees are all trained on PIPEDA (The Personal Information Protection and Electronic Act) this is a Canadian law relating to data privacy. It governs how the private sector organizations collect, use and disclose personal information in the course of commercial business.

I, _____ hereby certify that I have been notified of the
PRIVACY POLICIES OF GEORGIAN MALL DENTAL GROUP

Signature: _____ Checked by: _____

❍ Patient ❍ Parent ❍ Guardian Checked by:

Print Name: _____

Signature: _____

Date: _____

Consent for electronic billing
I authorize release, to my dental benefit plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentists. This authorization shall continue in effect, until the undersigned revokes the same.

Signature of Patient, Parent / Guardian: _____ Date: _____

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New Patient Registration Form

The Following information is required to enable us to provide you with the best possible care.
All information is strictly private and is protected by doctor - patient confidentially. The Dentist will review the questions and explain any that you do not understand. Please fill out this entire form.

Full Name: _____
Date of birth (DD/MM/YY): ____/____/____
Address (home) : _____
Doctor's phone/address: _____
Phone (home): _____
Address (bus.): _____
Area of specialty: _____
Phone (bus.): _____
Marital status: _____
Email: _____
Health card no.: _____
Employer: _____
Specialist's phone/address: _____
Occupation: _____

Relationship: _____
Day-time phone: _____
Family doctor: _____
_____

(1) Name of medical specialist: _____
_____
Specialist's phone/address: _____

(2) name of medical specialist: _____
Area of specialty: _____

Policy holder	Primary insurance	Secondary insurance	Patient/guardian signature
Name & DOB			
DD/MM/YYYY)			
Relationship			
Insurance company			
Group/policy no.			
Certificate no.			

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Medical History Questionnaire

Medical Alert: 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.

Full Name: _____
Date of birth (DD/MM/YY): ____/____/____
Address (home) : _____
Doctor's phone/address: _____
Phone (home): _____
Address (bus.): _____
Area of specialty: _____
Phone (bus.): _____
Marital status: _____
Email: _____
Health card no.: _____
Employer: _____
Specialist's phone/address: _____
Occupation: _____

Relationship: _____
Day-time phone: _____
Family doctor: _____
_____

(1) Name of medical specialist: _____
_____
Specialist's phone/address: _____

(2) name of medical specialist: _____
Area of specialty: _____

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain.

❍ Yes ❍ No ❍ Not sure/ Maybe _____

_____

2. When was your last medical checkup? _____

_____

3. Has there been any change in your general health in the past year? If yes, please explain.

❍ Yes ❍ No ❍ Not sure/ Maybe _____

_____

4. Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? If yes, please list them.

❍ Yes ❍ No ❍ Not sure/ Maybe _____

_____

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Medical History Questionnaire

5. Do you have any allergies? If yes, please list them using the categories below: ❍ Yes ❍ No ❍ Not sure/ Maybe

a) Medications: _____

b) Latex/rubber products: _____

c) Other: _____

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

❍ Yes ❍ No ❍ Not sure/ Maybe _____

7. Do you have or have you had asthma? ❍ Yes ❍ No ❍ Not sure/ Maybe

8. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?

❍ Yes ❍ No ❍ Not sure/ Maybe

9. Do you have a prosthetic or artificial joint? ❍ Yes ❍ No ❍ Not sure/ Maybe

10. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ❍ Yes ❍ No ❍ Not sure/ Maybe

11. Have you ever had hepatitis, jaundice, or liver disease? ❍ Yes ❍ No ❍ Not sure/ Maybe

12. Do you have a bleeding problem or bleeding disorder? ❍ Yes ❍ No ❍ Not sure/ Maybe

_____

13. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.

❍ Yes ❍ No ❍ Not sure/ Maybe

14. Do you have or have you ever had any of the following? Please check.

❍ Chest pain, angina	❍ Rheumatic fever	❍ Pacemaker	❍ Steroid therapy
❍ Seizures (epilepsy)	❍ Heart attack	❍ Mitral valve prolapse	❍ Lung disease
❍ Diabetes	❍ Kidney disease	❍ Stroke, TIA	❍ Tuberculosis
❍ Stomach ulcers	❍ Thyroid disease	❍ Shortness of breath	❍ Heart murmur
❍ Cancer	❍ Arthritis	❍ Drug/alcohol/cannabis use or dependency	❍ Osteoporosis medications (E.G. Fosamax actonel)

15. Are there any conditions or diseases not listed above that you have had? If yes, please explain.

❍ Yes ❍ No ❍ Not sure/ Maybe

_____

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Medical History Questionnaire

16. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, or heart disease)?
❍ Yes ❍ No ❍ Not sure/ Maybe

17. Do you smoke or chew tobacco products? ❍ Yes ❍ No ❍ Not sure/ Maybe

18. Are you nervous during dental treatment? ❍ Yes ❍ No ❍ Not sure/ Maybe

19. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
❍ Yes ❍ No ❍ Not sure/ Maybe

_____

20. Do you identify as a patient with a disability? If yes, please explain.
❍ Yes ❍ No ❍ Not sure/ Maybe

_____

General Release: I, the undersigned, understand that in information contained in the medical and dental history is important to my treatment. I certify that all information I have completed is correct and that i have not knowingly omitted data. I consent to the release of the medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostics procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for the dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

Dentist Signature: