Cedar Dental CENTRE

Add: 65 Cedar Street, Cambridge Ontario, N1S 1V5
E-mail: info@cedardentalcentre.com
Ph: 519 621 3770

NEW PATIENT FORM

Patient Information

A parent or guardian will be responsible for decisions on my treatment ☐ Yes ☐ No

Medical Alert

First Name | Initial Name | Last Name

Date Of Birth | Street | Apt.

City | Prov. | Postal Code

Home Tel | Work Tel | Cell

Email | Referred By

Emergency Contact | Tel.

Family Doctor | Tel.

Financial Information

Method of Payment ☐ Cash ☐ Credit Card ☐ Insurance ☐ Others

Person responsible for financial matters ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Others

If Different From Above

First Name | Initial Name | Last Name

Date Of Birth | Street | Apt.

City | Prov. | Postal Code

Home Tel | Work Tel

Primary Insurance

Driver's LIC | ID#

Ins. Company | Employer

Policy Holder | Date Of Birth

Policy | Certificate#

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Secondary Insurance

Driver's LIC ☐

ID# ☐

Ins. Company ☐

Employer ☐

Policy Holder ☐

Date Of Birth ☐

Policy ☐

Certificate# ☐

Medical History

1. Are you presently under the care of a physician? If so,explain. ☐ Yes ☐ No
2. Have you ever been hospitalized? Explain. ☐ Yes ☐ No
3. When was you last medical checkup? ☐
4. Are you taking any drug or medication at this time? ☐ Yes ☐ No
5. Do you have any allergies? ☐

Please tick appropriate boxes. ☐ None ☐ Local Anesthetic ☐ Latex/Rubber ☐ Antibiotics ☐ Others

6. Do you bruise easily or have prolonged bleeding? ☐ Yes ☐ No
7. Do you have or have you ever had asthma? ☐ Yes ☐ No
8. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No
9. 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 condiiton from birth (i.e. congenital heart disease) or a heart transplant? ☐ Yes ☐ No
10. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No
11. Do you have any condition or therapies that could affect your immune system. e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ☐ Yes ☐ No
12. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No
13. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ☐ Yes ☐ No
14. Do you smoke or chew tobacco products? How much per day? ☐ Yes ☐ No
15. Have you ever fainted, had shortness of breathe or chest pains? ☐ Yes ☐ No
16. **WOMEN**

Are you pregnant? ☐ Yes ☐ No

Using Birth Control? ☐ Yes ☐ No

Reached menopause? ☐ Yes ☐ No

17. Do you have or have you ever had any of the following? Please tick appropriate boxes.

☐ Heart Attack ☐ Rheumatic Fever ☐ Cancer ☐ Steroid Therapy ☐ Stroke ☐ Osteoporosis Medications ☐ Seizures (epilepsy)
☐ Arthritis ☐ Heart Murmur ☐ Diabetes ☐ Kidney Disease ☐ Tuberculosis ☐ Pacemaker ☐ Lung Disease
☐ Stomach ulcer ☐ Thyroid Disease ☐ Mitral Valve Prolapse ☐ Drug/Alcohol Dependency

18. Are there any conditions or diseases not listed above that you have or had? If so what? ☐

Dental History

1. What is the reason for today's visit? ☐ Emergency ☐ Examination ☐ Others ☐
2. How frequently do you see a dentist? ☐ 3-6 months ☐ Annually ☐ Others ☐
3. When was your last dental visit? ☐ Last X-ray? ☐
4. How often do you brush per day ☐ Floss? ☐

Use anti-bacterial rinse? ☐

5. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Others ☐

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6. Do your gums bleed when: ☐ Yes ☐ No
7. Do your jaws crack or pop when you open widely? ☐ Yes ☐ No
8. Do you grind or clench your teeth? ☐ Yes ☐ No
9. Are you nervous during dental treatment? ☐ Yes ☐ No
10. Would you prefer sedation for dental treatment? ☐ Yes ☐ No
11. Have you ever had any problems with previous dental treatments? ☐ Yes ☐ No

Specify

12. Have you ever had any of the following:

☐ Bridgework ☐ Crowns or Caps ☐ ull or Partial Dentures ☐ Orthodontic (braces) ☐ Periodontal (Gums) Treatment ☐ Root Canal

13. Are you satisfied with your teeth? ☐ Yes ☐ No

Specify

General Release

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I hjave completed is correct and that I have not knowingly omitted data. I consent to the release of 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 diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility fro fees associated with my dental treatment or dental diagnostic procedures.

Signature/Self/parent/Guardian | Print Name | Date

Dentist Signature | Print Name | Date

Medication List

Are you currently taking any medications? ☐ Yes ☐ No

If Yes, Please list your medications:

1. Medication | 2. Medication | 3. Medication

4. Medication | 5. Medication | 6. Medication

7. Medication | 8. Medication | 9. Medication

10 Medication

Signature | Date | Dentist Signature

Payment Policy

he full payment for services rendered within the office is expected at the end of each appointment. For your convenience, our office will send an electronic estimate ahead of time to your insurance company and then bill directly to them upon completion of the procedure. If the claim is not processed electronically, then we will ask for your signature on the appropriate forms so we can mail out a hard copy of the dental claim to your insurance.

For any charges that are not covered by your insurance or if you do not have dental insurance, you will be responsible for the remaining cost. We accept Visa, Mastercard, American Express, Debit, and Cash.

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Cancellation Policy

Please always arrive on time for your appointment. If you are running a few minutes late, please call our office to let us know. If you are significantly delayed, we may only be able to complete a partial treatment or may even have to ask you to reschedule depending on the remaining time left before the following patient's appointment.

We require at least 48 hours (or 2 business days) notice to cancel or reschedule your appointment. This allows us time to fill in the schedule in an attempt not to waste our dentists' and hygienists' time. We will try to be understanding to last minute cancellations for unexpected medical or personal emergencies, but repeat occurrences of last-minute cancellations or no-shows to your appointments will incur a $50.00 fee for the disruption.

I have read and understand the terms indicated above.

Signature

Date

COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

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

Enable us to contact you (your child) to book and confirm appointments.
To advise you of treatment options
To communicate with other health-care providers, including medical and dental specialists and general practitioners
To comply with legal and regulatory requirements, including the delivery of patient's charts and records to the Royal College or Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulatory health professions act.
To comply with agreements/undertakings entered into voluntarily by Dr. Ngoc D Steve Van, Dr. Puneet Gill or their associates with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the college in a timely fashion for regulatory and monitoring purposes.
To prepare material for the Health Professions Appeal and Review Board
To process credit card payments
To collect unpaid accounts.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the consequences of that decision, and the process.

By signing the consent section of this form, you have agreed that you have given your informed consent to collection, use and/or disclosure of your personal information for the purposes that are listen.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information. I agree that Dr. Ngoc D Steve Van, Dr. Puneet Gill or their associates 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 legislations.

Print Name

Signature

Date

Signature Witness