Dentistry At Clarkson

Dr. Sharmila Shettigar
960 Southdown Rd. Unit C3, Mississauga ON L5J 2Y4
T: 905.823.7855 E: Admin@DentistryAtClarkson.com

The personal information provided below will be protected and kept private by our office. All information will be used and disclosed responsibly according to the Private Act standards set up and monitored by our office.

☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐ Dr. Name:_____Last Name: _____

Prefer to be called:_____Pronunciation:_____Date of birth: _____
Marital Status:_____ MM/DD/YY

Address: _____
(STREET) (APT.#) (CITY) (POSTAL CODE)

Home Phone: (_____) -_____-_____ Email Address: _____

Mobile Phone:(_____) -_____-_____ Preferred Contact Method: _____

Are you likely to be available on short notice for future appointments? ☐ Yes ☐ No

How did you find out about our office?

☐ Google ☐ Internet ☐ Smiles Savers Program ☐ Referral ☐ Other: _____
If referred, who may we thank for referring you to our office? _____

Family Physician:_____Phone: (_____)-_____-_____

Emergency Contact:_____Relation:_____Phone: (_____)-_____-_____

Person Responsible for this Account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Others

Name:_____Last Name:_____Relation: _____

☐ Same address as above – If different please fill below.
Address: _____
(STREET) (APT.#) (CITY) (POSTAL CODE)

Home Phone: (_____)-_____-_____ Email Address: _____

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber:_____	Subscriber:_____
Date of Birth:_____/_____/_____ DD MM YR	Date of Birth:_____/_____/_____ DD MM YR
Relation: ☐ Self ☐ Spouse ☐ Parent	Relation: ☐ Self ☐ Spouse ☐ Parent
Insurance Company: _____	Insurance Company: _____
Policy/Plan #: _____	Policy/Plan #: _____
ID/Certificate #: _____	ID/Certificate #: _____
Are youfamiliar with your dental plan? ☐ Yes ☐ No	***Are youfamiliar with your dental plan?*** ☐ Yes ☐ No

Method of Payment: ☐ Cash ☐ Debit ☐ Credit Card:_____Exp: _____
MM / YR

DENTAL HISTORY

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist:_____How long have you been a patient?_____Months/Years
Date of most recent dental exam:_____Date of most recent x-rays: _____
Date of most recent treatment (other than a cleaning): _____

I routinely see my dentist every: ☐ 3 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ Not routinely
What is your immediate concern? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	**YES**	**NO**
1. Are you fearful of dental treatment? How fearful on a scale of 1 (least) to 10 (most) [_____]	☐	☐
2. Have you ever had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	☐	☐
6. Have you had any teeth removed?	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change?	☐	☐
8. Have you ever whitened (bleached) your teeth?	☐	☐
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth?	☐	☐
10. Have you been disappointed with the appearance of previous dental work?	☐	☐
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping)	☐	☐
12. Do you have any problems chewing gum?	☐	☐
13. Do you have any problems with chewing bagels, baguettes, protein bars or other hard foods?	☐	☐
14. Have your teeth changed in the last 5 years, become shorter, thinner, or worn?	☐	☐
15. Are your teeth crowding or developing spaces?	☐	☐
16. Do you have more than one bite and squeeze to make your teeth fit together?	☐	☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
18. Do you clench your teeth in the daytime or make them sore?	☐	☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth?	☐	☐
20. Do you wear, or have you ever worn a bite appliance?	☐	☐
TOOTH STRUCTURE		
21. Have you had any cavities within the past 3 years?	☐	☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
23. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth?	☐	☐
24. Are any teeth sensitive to hot, cold, biting sweets, or avoid brushing any part of your mouth?	☐	☐
25. Do you have grooves or notches on your teeth near the gum line?	☐	☐
26. Have you ever had broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
27. Do you frequently get food caught between your teeth?	☐	☐
28. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
GUM AND BONE		
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
31. Is there anyone with a history of periodontal disease in your family?	☐	☐
32. Have you ever experienced gum recession?	☐	☐
33. Have you ever had any teeth become loose on their own (without injury), or do you have difficulty eating an apple?	☐	☐
34. Have you experienced a burning sensation in your mouth?	☐	☐

MEDICAL HISTORY

The following is required by the dentist to assist in proper diagnosis and treatment.

1. Have you ever had a serious illness requiring hospitalization or extensive medical care? ☐ Yes ☐ No
   Please Specify:

   _____

2. Are you presently under the care of a physician? ☐ Yes ☐ No
   Please Specify:

   _____

3. Have you had a medical examination in the last year? ☐ Yes ☐ No
4. Do you use any prescription or non-prescription drugs regularly? ☐ Yes ☐ No
   Please Specify:

   _____

5. Do you have allergic conditions: e.g., hay fever, skin rash, food allergies, metal, latex? ☐ Yes ☐ No
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? ☐ Yes ☐ No
7. Have you been hospitalized in the last 5 years? ☐ Yes ☐ No
8. Have you ever experienced any unusual reaction to any of the following?

   ☐ Local anesthesia ☐ Aspirin ☐ Penicillin
   ☐ Codeine ☐ Sulpha drugs ☐ Barbiturates (sleeping pills)
   ☐ Any other Medicine.
   Please Specify: _____

9. Have you been warned against taking any drugs or medication? ☐ Yes ☐ No
10. Do you bruise easily or bleed abnormally? ☐ Yes ☐ No
11. Do you require pre-medication for dental treatment? ☐ Yes ☐ No
12. Have you ever had any organ implants or medical implants? ☐ Yes ☐ No
13. Have you ever fainted? ☐ Yes ☐ No
14. Do your ankles swell? ☐ Yes ☐ No
15. Do you experience shortness of breath, chest pain when taking a walk or climbing stairs? ☐ Yes ☐ No
16. Do you have frequent headaches? ☐ Yes ☐ No
17. Do you have A.I.D.S or have you ever tested positive for H.I.V.? ☐ Yes ☐ No
18. Do you have any of the following? *Please check all that apply.*

☐ Arthritis or Rheumatism	☐ Cancer/ Chemotherapy	☐ Cold Sores
☐ Cortisone/ Steroid Therapy	☐ Diabetes	☐ Drug/Alcohol Dependency
☐ Emphysema	☐ Epilepsy or Seizures	☐ Glaucoma
☐ Heart Attack	☐ Heart murmur/Mitral Valve Prolapse	☐ Hepatitis A / B / C
☐ Herpes	☐ High Blood Pressure	☐ Hyper Glycemia
☐ Jaundice	☐ Joint Replacement (i.e., Hip, knee)	☐ Kidney Problems
☐ Liver Disease	☐ Low Blood Pressure	☐ lung disease (i.e., Asthma)
☐ Malignant Hyperthermia	☐ Mental/Nervous Disorder	☐ Scarlet or Rheumatic Fever
☐ Sinus Trouble	☐ Stomach/Intestinal Problems/ Ulcers	☐ Stroke
☐ Thyroid Disease	☐ Tuberculosis	☐ Venereal Disease

   ☐ Other: _____

19. Have you had any injury, surgery, or x-ray therapy to your face or jaws? ☐ Yes ☐ No
20. Do you have any disease, condition, or problem that you think the doctor should know about? ☐ Yes ☐ No
    If Yes, Please Specify:

    _____

21. ***WOMEN ONLY –*** Are you pregnant or suspect you might be? ☐ Yes ☐ No
    If Yes, what month are you in? _____

    Are you taking birth control? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

PRIVACY ACT NOTIFICATION

I have been informed of the privacy policy of this office and understand that all information I have supplied will be used and disclosed as set out within this office policy.

OFFICE POLICY

Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require a 48-hour cancellation notice, otherwise it may be necessary to charge you for time lost.

PATIENT RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any question regarding my medical-dental history. I authorize the dentist to perform diagnostic with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that my responsibility for my payment for the dental services provided for my dependents and myself is mine, and I will assume responsibility for fees associated with these services.

(*Signature*)

_____/_____/_____
MM DD YR

☐ Patient ☐ Parent ☐ Legal Guardian

Reviewing Dentist: _____

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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 collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Dr. Sharmila Shettigar acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you.
- We only share your information with your consent.
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols.
- Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality dental care.

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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 here how our office is using and disclosing your information.

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

- to deliver safe and efficient patient care
- to identify and to ensure continuous high-quality service.
- to assess your health needs
- to provide health care
- to advise you of treatment options
- to enable us to contact you.
- to establish and maintain communication with you.
- to offer and provide treatment, care, and services in relationship to the oral and maxillofacial complex and dental care generally.
- to communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists.
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments.
- to allow us to efficiently follow-up for treatment, care, and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit dental claims for third party adjudication and payment.
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the *Regulated Health Professions Act*
- to comply with agreements/undertakings entered into voluntarily by the member 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 deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements.

- to comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the *Regulated Health Professions Act* (RHPA*)* for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

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

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that ***Dr. Sharmila Shettigar/ Dentistry at Clarkson*** can collect, use and disclose personal information about_____(Name of Patient) as set out above in the information about the office's privacy policies.

Patient's/Guarantor's Name: _____ Date: _____

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PATIENT FINANCIAL POLICIES

To Our Valued Patients:

- Patients are responsible to pay for treatment at the time the service is rendered (including patients with dental insurance). Your dental insurance company will reimburse you directly or your insurance will pay us directly.
- Dental insurance is a contract between your employer and the insurance company. Therefore, all insurance inquiries are to be done by the patient. Our friendly staff will assist you where possible.
- A 50% payment is required for all extensive treatment. The balance of the fee is to be paid upon completion of the treatment, unless written financial arrangements have been made in advance with our dental office.
- The patient is always responsible for seeing that the **ENTIRE FEE** is paid in full at the time of the appointment. If we are billing the insurance directly, procedures not covered are to be paid by the patient. Patients are expected to keep us update about their insurance policies.
- Benefit coverage is a contract between yourself, the insurance company, and your employer, not the dentist.
- Appointments missed without a 48-hour notice will result in a $75.00 charge.
- For your convenience, we accept the following form of payment: cash, direct deposit, Visa, American Express and Mastercard.

As a courtesy, our office will file your claim with your insurance company.

If you have any questions, please feel free to speak with our Admin staff.

We thank you for your cooperation.

I have read and understood the above policies and agree with them.

Patient's/Guarantor's Name: _____Date:_____