ROSEGATE DENTAL CENTRE

Patient Info & Medical History

216 Oak Park Blvd # 4
Oakville Ontario
L6H 7S8
P: (905) 257-6255
info@rosegatedental.ca

Patient Name

Address _____ City _____ Postal Code _____

Phone (home) _____ (cell) _____ Sex M ☐ F ☐ Age _____ Birth Date M____D____Y___

Adult Patient

Occupation _____
Employer _____
Phone (work) _____
Email _____

Child Patient (Indicate Who is responsible for this account below)

Mother's Name _____
Employer _____ Phone (Work) _____
Father's Name _____
Employer_____ Phone (Work) _____

Marital Status M ☐ S ☐ W ☐ D☐

Dental Insurance No ☐ Yes☐ Company _____ (policy #)/(ID #) _____ Health Card #:

1. **Have you been under the care of a medical doctor during the past two years?** Yes ☐ No ☐
   If yes, for what?
   Physician's Name _____ Phone _____
2. **Have you taken any prescription medication or drugs during the past two years?** Yes ☐ No ☐
3. **Are you taking any prescription medication, drugs or pills now?** Yes ☐ No ☐
   If yes, please list the name and dosage
4. **Are you aware of having an allergic (or adverse) reaction to any medication or substance?** Yes ☐ No☐
   If yes, please list
5. **Have you been hospitalized in the last five years?** Yes ☐ No ☐
6. **Indicate which of the following you have had, or presently have (please place an "X" in the box, if nothing please cross out column)**

☐ Heart (Surgery, Disease, Attack)	☐ Chest Pain	☐ Yellow Jaundice
☐ Latex Sensitivity	☐ Congenital Heart Disease	☐ Venereal Disease
☐ Stomach Ulcers	☐ Heart Murmur	☐ A.I.D.S
☐ Diabetes	☐ High Blood Pressure	☐ H.I.V. Positive
☐ Thyroid Problems	☐ Artificial Heart Valve	☐ Cold Sores/ Fever Blisters
☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Blood Transfusion
☐ Emphysema	☐ Heart Pacemaker	☐ Hemophilia
☐ Chronic Cough	☐ Rheumatic Fever	☐ Sickle Cell Disease
☐ Tuberculosis	☐ Arthritis/Rheumatism	☐ Bruise Easily
☐ Asthma	☐ Cortisone Medicine	☐ Neurological Disorders
☐ Hay Fever	☐ Swollen Ankles	☐ Epilepsy or Seizures
☐ Allergies or Hives	☐ Stroke	☐ Fainting or Dizzy Spells
☐ Sinus Trouble	☐ Diet (Special/Restricted)	☐ Nervous / Anxious
☐ Radiation Therapy	☐ Artificial Joints (hip, knee, etc.)	☐ Psychiatric / Psychological Care
☐ Chemotherapy	☐ Kidney Trouble	
☐ Tumors	☐ Hepatitis	
☐ Do You Smoke	☐ Liver Disease	

7. **Do you have, or had any disease, or problem not listed?**
   If yes, please list _____
8. **Women** Are you: **Pregnant?** Yes _____ Months No ☐ **Nursing?** Yes ☐ No ☐ **Taking Birth Control Pills?** Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the representative health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication

Print Name: _____ **Signature _____** **Date (mm/dd/yyyy) _____**

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Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses. (Collectively referred to as 'Contact Information")

Contact Information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients informational material about our dental practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatments or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition and dental treatments. (Collectively referred to as "Medical Information") Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf.
- To other dentists and dental specialists, where we are seeking a second opinion and the patient has consented to us obtaining the second opinion.
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

Cancellations & Missed Appointments

When you book an appointment with us, we reserve that time specifically for you to see the dentist or hygienist. As such, we require 48 hours notice in the event an appointment must be cancelled. This allows other patients awaiting treatment to be rescheduled into the time slot initially reserved for you.

I consent to the collection, use and disclosure of my personal information as set out above

Print Name: _____ Signature _____ Date (mm/dd/yyyy) _____