WELCOME TO OUR CLINIC

Patient ID #

DG
DENTURIST GROUP OF ONTARIO

CONFIDENTIAL PATIENT INFORMATION

CONTACT INFORMATION

LAST NAME:		FIRST NAME:
SALUTATION: SELECT	SEX: ☐ F ☐ M ☐ OTHER	BIRTHDATE:
ADDRESS:		APT:
CITY:	COUNTRY:	POSTAL/ZIP CODE:
PHONE (HOME):	(WORK):	(CELL):
OCCUPATION:		EMPLOYER:
ACCOUNT RESPONSIBILITY:		
EMERGENCY CONTACT	FIRST NAME:	LAST NAME:
RELATIONSHIP TO PATIENT:		PHONE:
HOW DID YOU HEAR ABOUT US?		
REASON FOR THIS VISIT:		

PRIMARY INSURANCE POLICY

POLICY HOLDER:		BIRTHDATE:
RELATIONSHIP WITH PATIENT:		
INSURANCE COMPANY:		EMPLOYER:
GROUP / POLICY #:		CERTIFICATE / ID #:
COVERAGE BASIC:		% MAJOR: %
CALENDAR YEAR:		

SECONDARY INSURANCE POLICY

POLICY HOLDER:		BIRTHDATE:
RELATIONSHIP WITH PATIENT:		
INSURANCE COMPANY:		EMPLOYER:
GROUP / POLICY #:		CERTIFICATE / ID #:
COVERAGE BASIC:		% MAJOR: %
CALENDAR YEAR:		

DENTAL HISTORY

DENTIST:	
ADDRESS:	
PHONE:	LAST DENTAL VISIT:
FREQUENCY OF DENTAL VISITS:	

Patient ID #

DENTAL HISTORY (CONTINUE)

PLEASE INDICATE YES (Y) OR NO (N) TO THE FOLLOWING:	Y	N
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD	☐	☐
DO YOU FEEL PAIN IN ANY OF YOUR TEETH	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
DO YOU BITE YOUR LIPS / CHEEKS FREQUENTLY	☐	☐
DO YOU HAVE ANY MOBILE TEETH	☐	☐
DO YOU WEAR COMPLETE OR PARTIAL DENTURES?	☐	☐

IF YES, DATE OF PLACEMENT

DATE OF LAST RELINE

MAIN PROBLEM WITH EXISTING DENTURE(S):

HAVE YOU EXPERIENCE ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?	Y	N
CLICKING	☐	☐
PAIN	☐	☐
DIFFICULTY IN OPENING / CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE DENTAL IMPLANTS?	☐	☐

IF YES, DATE OF PLACEMENT:

ADDITIONAL COMMENTS / CONCERNS

THE INFORMATION BELLOW IS REQUIRED TO PROVIDE THE DENTURIST WITH INFORMATION FOR QUALITY DENTAL CARE TO YOU. ALL OF THE INFORMATION IS KEPT PRIVATE AND IS PROTECTED BY STRICT CONFIDENTIALITY. PLEASE FILL IN ENTIRE FORM.

MEDICAL HISTORY

PHYSICIAN'S NAME:

PHONE:

ARE YOU PRESENTLY RECEIVING TREATMENTS FOR ANY ILLNESS?
☐ Y ☐ N IF YES, PLEASE PROVIDE DETAILS:

DO YOU HAVE ANY HEART OR CIRCULATORY CONDITIONS?
☐ Y ☐ N

DO YOU HAVE A PACEMAKER?
☐ Y ☐ N

DO YOU HAVE ANY ALLERGIES?
☐ Y ☐ N

IF YES, PLEASE PROVIDE DETAILS:

ARE YOU PRESENTLY TAKING MEDICATION(S)
☐ Y ☐ N

DRUG:	REASON:
DRUG:	REASON:
DRUG:	REASON:
DRUG:	REASON:
DRUG:	REASON:

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MEDICAL HISTORY (CONTINUE)

PLEASE INDICATE BELOW IF YOU PRESENTLY HAVE ANY OF THE FOLLOWING:

- ☐ AIDS / HIV
- ☐ ANXIETY / NERVOUS DISORDER
- ☐ ASTHMA
- ☐ CHEMOTHERAPY / RADIOTHERAPY
- ☐ EPILEPSY
- ☐ HEPATITIS
- ☐ THYROID
- ☐ HYPER / HYPOGLYCEMIA
- ☐ ARTHRITIS OR RHEUMATISM
- ☐ CANCER
- ☐ DIABETES
- ☐ FAINTING / DIZZY SPELLS
- ☐ HIGH / LOW BLOOD PRESSURE
- ☐ STROKE
- ☐ TUBERCULOSIS
- ☐ HEART ATTACK
- ☐ STOMACH ULCERS
- ☐ KIDNEY DISEASE
- ☐ SHORTNESS OF BREATH
- ☐ OSTEOPOROSIS
- ☐ THYROID DISEASE
- ☐ DRUG / ALCOHOL DEPENDENCY

DO YOU SMOKE? ☐ Y ☐ N

OTHER MEDICAL CONDITION:

Patient ID #

MEDICAL HISTORY (CONTINUE)

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 COLLEGE OF DENTURISTS 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 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 (DENTURIST NAME) _____
CAN COLLECT AND DISCLOSE MY PERSONAL INFORMATION PERTAINING TO MY TREATMENT, TO OTHER PROFESSIONALS AS NEEDED.

PATIENT SIGNATURE	DATE
PRINT NAME	SIGNATURE OF WITNESS

DENTURIST CARE CLAIM FORM

PATIENT

LAST NAME | FIRST NAME

ADDRESS | APT. NO.

CITY | PROVINCE

POSTAL CODE | TELEPHONE NO.

DENTURIST ID:

DATE SUBMITTED | AUTHORIZATION NO.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM AND AUTHORIZE PAYMENT DIRECTLY TO THE NAMED DENTURIST

SIGNATURE OF SUBSCRIBER

PATIENT INFORMATION

BIRTH DATE

RELATIONSHIP TO EMPLOYEE PLAN MEMBER

☐ SPOUSE ☐ SON ☐ DAUGHTER ☐ SELF

IS THIS PATIENT COVERED UNDER ANOTHER CONTRACT PROVIDING DENTAL CARE?

☐ YES* ☐ NO

* IF YES, NAME OF INSURER GROUP NO./POLICY NO./PLAN NO.

DATE OF BIRTH (SPOUSE)

DATE OF EXTRACTIONS

IF PATIENT HAS EXISTING APPLIANCE WHEN WAS IT PLACED?

PROSTHESIS

☐ INITIAL ☐ REPLACEMENT ☐ RELINE ☐ REPAIR

- ARE SERVICES REQUIRED AS A RESULT OF AN ACCIDENT? IF YES ATTACH DETAIL

  ☐ YES ☐ NO

- IS A CLAIM BEING MADE FOR WORKPLACE SAFETY & INSURANCE BOARD BENEFITS?

  ☐ YES ☐ NO

EMPLOYEE'S INFOMATION

INSURANCE COMPANY

GROUP POLICY NO.

DIVISION/SECTION NO. | CERTIFICATE NO.

LAST NAME | FIRST NAME

BIRTH DATE | BUSINESS PHONE | HOME PHONE

ADDRESS (IF DIFFERENT THAN PATIENT'S)

EMPLOYER'S NAME

DATE SERVICE COMPLETED	PROCEDURE CODE	DESCRIPTION OF SERVICE	DENTURIST CLINICAL FEE	LABORATORY CHARGES	TOTAL CHARGES
			$	$	0.00 $
			$	$	0.00 $
			$	$	0.00 $
			$	$	0.00 $
			$	$	0.00 $
			$	$	0.00 $

DENTURIST USE ONLY

ADDITIONAL INFORMATION

☐ FOR PRE-AUTHORIZATION ONLY

THIS IS AN ACCURATE STATEMENT OF SERVICES PERFORMED AND TOTAL FEES DUE AND PAYABLE EXCEPT ERRORS AND OMISSIONS.

TOTAL FEE CLAIMED

0.00 $

DENTURIST SIGNATURE / OFFICE STAMP

MARK TEETH BEING REPLACED BY PARTIAL DENTURE

☐18 ☐17 ☐16 ☐15 ☐14 ☐13 ☐12 ☐11 ☐21 ☐22 ☐23 ☐24 ☐25 ☐26 ☐27 ☐28

☐48 ☐47 ☐46 ☐45 ☐44 ☐43 ☐42 ☐41 ☐31 ☐32 ☐33 ☐34 ☐35 ☐36 ☐37 ☐38

I UNDERSTAND THAT THE FEES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY PLAN BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE ENTIRE TREATMENT.

I ACKNOWLEDGE THAT THE TOTAL AMOUNT DISPLAYED HEREUNDER IS ACCURATE AND HAS BEEN CHARGED TO ME FOR SERVICES RENDERED. I AUTHORIZE RELEASE OF ANY ADDITIONAL INFORMATION REQUIRED WITH RESPECT TO THIS CLAIM TO MY INSURANCE COMPANY / PLAN ADMINISTRATOR. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED IN THIS FORM TO THE NAMED DENTURIST.

$

SIGNATURE OF PATIENT (PARENT/GUARDIAN)

DATE

COMPLETED BY EMPLOYER

	EFFECTIVE DATE
▪ INDIVIDUAL	
▪ FAMILY	
▪ DATE OF EMPLOYMENT	
▪ TERMINATION	

SIGNATURE

CLASS

TITLE

DATE