ESTABLISHED 2017

ELECTRIC CITY DENTAL

DR. VERONA SULJA — FAMILY DENTISTRY — DR. KOREN BENNETTS

SULJA BENNETTS DENTISTRY PROFESSIONAL CORPORATION

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Today's Date: ______________________

Name: ______________________ Birth Date: ______________ Gender: ______________

Address: ______________________ City: ______________ Postal Code: ______________

Home Ph: ______________ Cell Ph: ______________ Work Ph: ______________

Email: ______________________ Preferred method of contact: email ☐ Ph: home ☐ Cell ☐

Occupation: ______________________ Employer: ______________________

Dental Insurance Co: ______________ Group #: ______________ Certificate #: ______________

Insurance Policy Holder's Name and Birthdate: ______________________ Relationship to Patient: ______________

Person to contact in case of emergency: ______________ Relationship: ______________ Phone #: ______________

Is any other member of your family a patient at our office? ______________________

How did you hear about our office? ______________ Whom may we thank for referring you? ______________

PATIENT MEDICAL HISTORY

Physician: ______________________ **Ph:** ______________

	Yes	No	Not Sure/Maybe
1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so why? ______________	☐	☐	☐
2. Was your last medical check-up within the past one year? If **no,** when was it? ______________	☐	☐	☐
3. Has there been any change in your general health in the past year?	☐	☐	☐
4. Are you taking any medications or non-prescription drugs of any kind?	☐	☐	☐
Please list name of medication & its usage: ______________________			
5. Do you have allergies to latex or food dyes?	☐	☐	☐
If yes, please list allergy ______________________			
6. Have you ever had allergic or adverse reaction to any medicines or injections? (e.g. penicillin, aspirin, or local anaesthetics, "dental freezing") ______________	☐	☐	☐
7. Have you ever been advised that you require antibiotic pre-medication prior to dental appointments?	☐	☐	☐
8. Have you ever been hospitalized for any illnesses or operations?	☐	☐	☐
Please explain: ______________________			
9. Do you have any developmental delays or neurodevelopmental disorders?	☐	☐	☐

See over →

10. Do you have or have you ever had any of the following? – **Please select all that apply.**

☐ Chest Pain ☐ Lung Disease ☐ Steroid Therapy ☐ Arthritis ☐ High Blood Pressure ☐ Heart Attack ☐ Tuberculosis
☐ Diabetes ☐ Seizures ☐ HIV/AIDS ☐ Stroke ☐ Asthma ☐ Stomach Ulcers ☐ Cancer ☐ Kidney Disease
☐ Hepatitis ☐ Bleeding Disorder ☐ Artificial Heart Valve ☐ Psychiatric Care/Mental Health
☐ ADD/ADHD ☐ Hearing Impairment

	Yes	No	Not Sure/Maybe
11. Are there any conditions or diseases not listed above that you have or have had? If so, what? ______________________________	☐	☐	☐
12. Do you smoke? Please circle: Cigarettes Vape Marijuana If so, how much?______________________________			
13. Do you use any recreational drugs on a regular basis?	☐	☐	☐
14. Do you drink alcohol on a regular basis?	☐	☐	☐
15. How nervous are you during dental treatments? (indicate by marking this scale below) **NOT AT ALL —1—2—3—4—5—VERY ANXIOUS**			
16. If you are nervous, would you like us to consider additional techniques, along with "freezing", to help you? i.e. laughing gas	☐	☐	☐
17. Have you ever had any serious trouble with any previous dental treatments?	☐	☐	☐
18. **For women only. Are you pregnant?** If so, what is the expected delivery date?______________________	☐	☐	☐

PATIENT DENTAL HISTORY

Name of previous dentist:______________________ Date of last visit:______________________

Describe any dental pain/discomfort: ______________________________

____

Describe what you would like done with your teeth: ______________________________

____

I certify that I have read and answered the above information accurately and to the best of my knowledge.

Consent For Treatment: This is to certify that I, the undersigned, verify the above information is true. I consent to the performing of dental procedures agreed to be necessary or advisable and will assume responsibility for fees associated with such procedures. I have read the office's privacy policy and I am aware of circumstances where it may be necessary to release or to obtain patient information. I give permission for photographs to be taken at my dental appointments.

PERMISSION FOR ELECTRONIC TRANSMISSION

I authorize release, to my dental benefits 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 dentist.

This authorization shall continue in effect until the undersigned revokes the same.

______________________________ ______________________________

Signature of patient, parent or guardian Date

Personal Information Consent Form

We at Electric City Dental are committed to protecting the privacy of our patient's 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 invoices 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 treatment 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"). Patient's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient's 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 patient's 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.

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Royal College of Dental Surgeons of Ontario which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

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

Patient /Guardian (Print)____

Patient/Guardian (Signature)______________________________________

Date ____

Witness ____

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Sulja Bennetts Dentistry Professional Corporation