REGISTRATION FORM

PATIENT NAME _____

Date of Birth_____ Married_____ or Single_____ Gender: _____

Address: Street_____ Apartment/Unit_____

City_____ Province: _____ Postal Code_____

Phone (Home)_____ Phone (Mobile) _____ Email_____

Preferable contact method: O Phone call O message O email

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may following questions. have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the questionnaire.

Are you under a physician's care now? If yes, please explain:
Name of the Physician _____
_____Phone_____

Have you ever been hospitalized or had a major operation? If yes, please explain:
_____

Have you ever had a serious head or neck injury? If yes, please explain:
_____

Are you taking any medications, pills, or drugs? If yes, please list them:
_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? If yes, please explain:
_____

Do you use tobacco? If yes, amount: _____

Have you ever had any complication following dental treatment? If yes, please explain: _____-
_____

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Local anesthetics O Acrylic O Metal O Latex O Sulfas drugs
Other: If yes, please explain: _____

Do you have, or have you had, any of the following?

O AIDS/HIV Positive	O Diabetes	O Heart Disease	O Recent Weight Loss
O Anaphylaxis	O Drug Addiction	O Hemophilia	O Rheumatic Fever
O Anemia	O Emphysema	O Hepatitis A	O Sinus Trouble
O Angina	O Epilepsy or Seizures	O Hepatitis B or C	O Stomach/Intestinal Disease
O Arthritis/Gout	O Excessive Bleeding	O High Blood pressure	O Stroke
O Artificial Heart Valve	O Fainting Spells/Dizziness	O Kidney Problems	O Thyroid Disease
O Artificial Joint	O Glaucoma	O Liver Disease	O Tuberculosis
O Asthma	O Hay Fever	O Mental Disorders	O Tumors or Growths
O Blood Disease	O Heart Attack/Failure	O Osteoporosis	O Ulcers
O Breathing Problem	O Heart Murmur	O Parathyroid Disease	O Venereal Disease
O Cancer	O Heart Pacemaker	O Renal Dialysis	O Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No _____

Comments:_____
_____

Royal City Dental 238 Speedvale Ave. W Guelph, On N1H 1C4
Tel: 519-836-6888 **Fax:** 519-836-7392 **Email:** info@royal-city-dental.com

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Royal City Dental understands the importance of protecting your personal information and our clinic is committed to protecting your individual privacy.
We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary to provide treatment and service to our patients:
1) To enable us to contact and maintain communication with you to distribute health-care information and to book and confirm appointments.
2) To assess your health needs and providing safe and efficient treatment, care and services in relationship to dental care.
3) To communicate with other health-care providers, including other dentists, physicians, pharmacists and specialist.
4) To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the RCDSO in a timely fashion, when required, according to the provisions of the Regulated Health Professionals Act. (RHPA)
5) To comply with agreements/ undertakings entered into voluntarily by the member with the RCDSO, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes.
6) To deliver records and charts information to the dentist's insurance carrier to enable insurance company to assess liability and quantify damages or coverage, as necessary.
7) To invoice for goods and services.
8) To process credit card payments.
9) To collect unpaid account.
10) To assist this office to comply with all regulatory requirements.

We collect information that you voluntarily give us and you may withdraw your consent, and we will explain the ramifications of that decision and the process. Personal health information is securely retained in accordance with RCDSO's (Royal College of Dental Surgeons of Ontario) guideline. Should you have any question, please contact our clinic's privacy officer, Dr. Juan C. Medina.

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 listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Thank you for your support and understanding in helping our office to comply with all regulatory requirements, and generally with the law.

PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

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 Royal City Dental – Dr. Juan C. Medina can collect, use and disclose personal information as set out above in the information about the offices privacy policies.

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Patient/Guardian Signature_____ Witness Signature_____

Patient/Guardian Print name_____ Date: _____

FINANCIAL POLICY

Thank you for choosing us for your dental needs! We are committed to providing you with excellent care and convenient financial arrangements. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patients' financial capabilities. To confirm your understanding and agreement with our policies, please read the following.

Payment: We strive to deliver the finest care at the most reasonable cost to our patients. For your convenience, we accept Visa, MasterCard, debit and cash. Personal cheques are not accepted.

We can provide an estimate for any dental treatment based on our professional assessment. This may be forwarded to your insurance company for pre-approval and determination of benefits.

We are willing to accept assignment (direct payment from your insurance company) as a courtesy to our patients. Although, as dental plans have become increasingly complicated and reimbursement levels are unpredictable, we must limit our payment terms to the following two options.

☐ Option 1:
Assignment of benefits secured with your credit card. We will continue to accept the assignment of your insurance benefits and collect the co-payment at the time of service. A credit card will be kept on file to process any payment not reimbursed to us. **(You will receive a courtesy call before we charge your card for any balance**)

☐ Option 2:
Non-Assignment of benefits with payment in full. Pay for your dental treatment in full on the day of your appointment by Visa, MasterCard, debit or cash. We can submit your dental insurance forms electronically the day of your visit, and you should be reimbursed within 3 – 10 days.

Please remember that you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Minors: A parent or guardian must accompany all minors to their dental appointments. The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit. It is not our responsibility.

Major Treatments (i.e.: crown, bridges, dentures, implants). A deposit (equal to lab fee) must be made no later than the day of the first appointment, for the remaining balance payment will be collected on the insertion/delivery appointment.

Financial Consent and Authorization for Treatment

We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family, regardless of any insurance coverage; your insurance policy is a contract between you and your insurance company. We cannot guarantee payment or coverage of your claim.

I agree to pay all fees and charges for services rendered at Royal City Dental for myself and my family. I agree to pay all charges when presented with a statement, unless prior credit arrangements are agreed upon in writing.

I understand and agree, regardless of my insurance status, I am ultimately responsible for any unpaid balance on my account.

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_____	_____	_____
Print Name	Signature	Date

Electronic Communication Consent. (You can withdraw your consent at any time)

□ I agree to receive email and/or text messages from Royal City Dental which may include appointment confirmations, newsletters, upcoming events and important notifications.