Authorization To Release Information and Authorization of Payment of Benefits

I hereby authorize Pavilion Dentistry to provide any insurance company (s), claim administrator (s) and consulting healthcare professionals, information concerning healthcare, advice, treatment, or supplies provided. This information with be used exclusively for the purpose of evaluating and administrating claims for benefits. I further authorize payment directly to Monarch Dentistry. I agree that a photocopy of this authorization is as valid as the original.

Signature:____ Date:________________

(If Patient is a minor, Parent or Guardian must sign here and complete section below)

PAYMENT AGREEMENT

I understand and agree that payment is due at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and myself. I understand that this office will prepare any necessary dental reports and dental forms to assist me in making collection from my insurance company, and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment, regardless of insurance.

In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

I understand that if I suspend or terminate any, care and treatment to me or any person referred to in the previous sentence any fees for professional services rendered will be immediately due and payable.

Signature:____ Date:________________

(If Patient is a minor, Parent or Guardian must sign here and complete section below)

RESPONSIBLE PARTY

(Dr/Mr/Mrs/Miss)____

First Middle Last Jr/Sr

____ Sex: M or F

SIN DOB

____

Street City Province Postal Code

_(_____)____________________________(_______)____

Home Phone Work Phone Employer

METHOD OF PAYMENT

How will you pay for today's visit? ☐Cash ☐Bank Check ☐ MasterCard ☐ Visa Card ☐ Other

Charge Card Authorization

By signing hereunder, I authorize Monarch Dentistry to bill my charge card account should any balance for services rendered that remain outstanding for more than (60) sixty days. If the account information given expires or is otherwise discontinued, I agree to give Monarch Dentistry information as to an alternate charge account, which may be used. My account is as follows:

☐ Visa ☐MasterCard ☐ Interact Card #____ Exp Date_______________

Signature________________________________ Date____________________

PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office, just as providing you with quality dental care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and as transparent as possible about the way we handle your personal information. It is VERY important to us to provide this service to all of our patients.
In this dental office, the dental centre manager acts as the privacy information officer. All team members who have 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. Here is an outlined policy that our office follows to ensure you that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and proper destruction of your personal information complies with the 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.

Please do not hesitate to discuss our policies with me or any member of our office staff and be assured that every team member in our office is committed to ensuring that you receive the best quality dental care.

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 and 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 access your health needs
- To advise you of treatment options
- To establish and maintain communication with you
- To enable us to contact 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 healthcare providers, including specialists and general dentists who are 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 effectively follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit dental claims and estimates for third party adjudication and payment

- To comply with legal and regulatory requirements, including the delivery of patient's 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 patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the dental practice
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- 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 should occur
- To prepare materials for the Health Professions Appeal and Review Board (HPARB)
- To invoice for goods and services
- To process credit card, cash and personal cheque payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements
- To comply generally with the law

By signing this consent section of this patient consent form, you agree 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 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 your permission to release the necessary information. We may also advise you if such a release is inappropriate. You may withdraw your consent for the 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 Pavilion Dentistry will use my personal information and the steps that Pavilion Dentistry is taking to protect all of my personal information. I agree that PAVILION DENTISTRY can collect, use and disclose personal information as set above in the information about Pavilion Dentistry's privacy policies.

______________________________	______________________________
Signature	Print Name
______________________________	______________________________
Date	Signature of Witness

CONSENT TO THE ADMINISTRATION OF LOCAL ANESTHETIC BY INJECTION

Any administration of local anesthetic by injection caries a risk of complications occurring. The following is a list of SOME of the most common OR most serious complications to occur in conjunction with any injection of local anesthetic:

- bleeding
- bruising
- infection
- swelling
- needle breakage
- soft tissue injury
- syncope (fainting)
- allergic reaction (mild or severe)
- intravascular injection
- more rarely; nerve damage resulting in areas of numbness, tingling or burning or other reduced/altered sensation (anesthesia/paresthesia). These can be temporary or permanent and involve any area of the head and neck including but not limited to the tongue, lips, cheeks, chin, neck, and face.

I understand that the alternatives to the use of local anesthetic are a general anesthetic or not using any anesthetic.

I have discussed all of the above with the doctor, and have had all of my questions answered to my satisfaction.

_______________________________________ _________________________________

Patient/parent/guardian Witness

____

Date

MEDICAL, DENTAL AND HEALTH HISTORY

The information that is requested on this questionnaire, dental history is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly.

PLEASE PRINT

REGISTRATION INFORMATION

The Patient is an: Adult_______Child______Adult Under Guardianship_______Name of Guardian: _______________

Name:____Mr.___Mrs.____Ms._____Miss.__Dr._____

Address:____Prov:______________Postal Code: _______________

Date of Birth: ______________________ Age: ______ Language Preference: ___________________

Phone Number (Best to Contact): (___)______:_________________ Home /Cell /Business (Circle One)

Who May We Thank for Referring You: ____

Are Other Family Members Patients at Our Office? Yes_______Names:____

Reason for Today's Visit: Examination___________Emergency_________Other ____

MEDICAL PRIORITY

Family Physician:____Phone: (_)___________________________

Medical Specialist:____Phone: (_)___________________________

Pharmacy:____Phone: (____)________________________

In Case of Emergency, Please Contact:____Phone: (_____)______________________

DENTAL INFORMATION

Date of Last Dental Visit?______________________________Last Dental Cleaning? ____

Last X-rays? ____

Have You Seen a Dentist Regularly? ______________________

Have You Been Advised to Take Antibiotics Before a Dental Appointment? Yes_____No_____

Have You Ever Had Any of the Following:

- Periodontal Treatment? (Treatment of the Gums) Yes_____No_____
- Orthodontic Treatment? (To Straighten or Realign Teeth) Yes_____No______
- A Bite Plate or Other Appliance/Denture? Yes_____No______
- Oral Surgery? (Surgery in or About the Mouth/Jaw Joint, or Implant in One or Both of Your Jaw Joints) Yes_____No_____

If You Answered 'Yes' to Any of the Last Questions, Who Performed the Surgery?___________________When? _______________

Are Any of Your Teeth Sensitive to Hot, Cold, Sweets or Pressure? Yes_____No______

Do You Have Emotional Concerns About Having Dental Treatment? Yes_____No_____

Have You Ever Had an Upsetting Experience in a Dental Office, or Any Complications During a Dental Treatment? Yes_____No_____

Would You Like Whiter Teeth? Yes_____No_____

What Do You Like Most About Your Smile? ____

What Are You Looking for to Improve Your Oral Health? ____

What Do You Look for Most in a Dentist/Dental Office? ____

Please Answer YES or NO to Each Question. If Unsure, Please Consult with the Dentist.

1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: ____Physician:______________Phone: _________________
2. Have you been hospitalized in the past two years? Yes_________No________
3. Are you presently taking any prescriptions or non-prescriptions drugs, including herbal remedies?
   a. ______________________ c. ______________________
   b. ______________________ d. ______________________

4. When was your last visit to a physician?________________Last medical examination? ____
5. Have you ever reacted adversely to any medications or injections? (Please circle) Penicillin, Aspirin, Codeine, Local Anesthetic(freezing), Nitrous Oxide, or any other medicine ______________________________
6. Do you have any allergies?___________________________________Do you require an Epi Pen? Yes____No ____
7. Is there a family history of Diabetes, Cancer or Heart Disease? Yes______No _______
8. Do you bleed EXCESSIVELY from a cut or injury or bruise easily? Yes______No _______
9. Do you experience shortness of breath or chest pain when taking a walk or climbing the stairs? Yes______No _______
10. Do you smoke tobacco, marijuana, other? Yes______No _______
11. **Women Only:** Are you pregnant or suspect you may be? Yes_____No_____Expected delivery date? ____________________ Are you breast feeding? Yes_____No ____________________
12. **INDICIATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR HAVE HAD IN THE PAST**

	YES	NO		YES	NO		YES	NO
A.I.D.S.			Glaucoma			Lupus		
Anemia			Head/neck Injuries			Malignant Hyperthermia		
Angina Pectoris			Heart Disease or Attack			Mental/Nervous Disorder		
Arthritis/ Rheumatism			Heart Murmur			Mitral Valve Prolapse		
Artificial Heart Valve			Heart Pacemaker			Organ Transplant/Medical Implant		
Artificial Joints (hip, knee)			Heart Rhythm Disorder			Psychiatric Treatment		
Blood Disorders			Heart Surgery			Radiation Treatment/Chemotherapy		
Cancer			Hepatitis A, B, C			Scarlet/ Rheumatic Fever		
Circulation Problems			Herpes			Sickle Cell Disease		
Congenital Heart Lesions			High/Low Blood Pressure			Sinus Trouble		
Cortisone/Steroids			Hodgkin's Disease			Stomach Problems		
Crohn's Disease			Hyper (Hypo) Glycemia			Stroke		
Diabetes			Inflammatory Bowel Disease			Thyroid Disease		
Emphysema			Jaundice			Tuberculosis		
Epilepsy or seizures			Kidney Disease			Ulcers		
Fainting or dizzy spells			Liver Disease			Venereal Disease		
Glandular Disorders			Lung Disease					

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and compete 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 questions I have had. **Should there be any change in either my health statue or any other information I have provided, I will advise immediately.** I authorize the dentist to perform diagnostic procedures as required to determine treatment. I understand that information provided from or to my medical doctor, or other health care providers may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, use and disclosed within the guidelines of the policy. I understand that the responsibility of payment of the dental services for myself and my dependents, is mine, and I assume responsibility for fees associated with these services.

Patient Name ____

Signature Patient/Parent/Guardian____**Date** __________________________________