PATIENT CONTACT INFORMATION

First Name: _____ Last Name: _____

Preferred Name: _____ Date of Birth:_____(DD/MM/YY) □ M □ F □Other

Address: _____ Apt/Unit#:_____

City: _____ Province:_____ Postal Code:_____

Phone Number: _____Email:_____

Employer: _____ Position:_____

Marital Status: □ Single □ Married/Common Law □ Other

In case of emergency – please notify: _____ Telephone Number:_____

REFERRAL INFORMATION

How did you hear about us?

□ Google □ Flyer □ Other Please specify:_____

INSURANCE INFORMATION

Primary Insurance Company Information

Name Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Insurance Company Name: _____

Secondary Insurance Company Information

Name Policy Holder: _____ Date of Birth: _____ (DD/MM/YY)

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Insurance Company Name: _____

PATIENT/GUARDIAN CERTIFICATION, APPROVAL AND CONSENT

I, the undersigned, certify all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information and consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic, sedation, x-rays as indicated. I authorize the dentist and his/her auxiliary staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided. I agree that King West Dentistry has obtained information consent from me with respect to the collection, use and disclosure if me personal health information. I have provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as asset out by the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection Act. 2004.

Patient (Parent, Guardian) Signature _____ Date_____

KING WEST DENTISTRY
Dr. A. Golabchifar & Associates

MEDICAL HISTORY

Family Physician Name:_____ Physician's Phone Number:_____

Please check any of the following that apply to you.

□ AIDS
□ Acid Reflux
□Anemia
□Anxiety
□Arthritis
(___Rheumatoid arthritis)
(___Osteoarthritis)
□Artificial Heart Valve
□Artificial Joints
□Asthma
□Blood Disorder
□Bruise Easily
□Cancer
□Chemotherapy
□Contraceptive
□Currently Pregnant
□Depression/Bipolar
□Diabetes
(___Type1, ___Type2)
□ Dizziness/Fainting
□Drug Addiction
□Emphysema
□Epilepsy
□Glaucoma
□ GERD
□Hay Fever
□Heart Conditions/Disease
□Heart Lesions, Congenital
□Heart Murmur
□Heart Surgery
□Hepatitis
(___A ___B ___C)
□High Blood Pressure
□Hives
□HIV Positive
□HPV
□Inflammatory Bowel Disease
(___Crohn's Disease)
(___ Ulcerative Colitis)
□Jaw Joint Pain
□Kidney/Liver Disease
□Low Blood Pressure
□Multiple Sclerosis
□ Osteoporosis
□Pacemaker
□Radiation (Head/ Neck)
□Respiratory Problems
□ Rheumatism
□ Scarlet Fever
□ Sinus Problems
□Smoking
□ Snoring/Sleep apnea
□Stroke
□Thyroid Disease
(___Hypo ___Hyper)
□ TMJ
□Tumour
□ Tuberculosis
□ Other (please specify)
_____
_____
_____

Are you currently taking or have been prescribed any medication? □ Yes □No

If yes, please specify_____

_____

Do you have any allergies to medications? □ Yes □No

□Codeine □Latex □Penicillin □Sulfa □Other_____

Do you take cannabis/cannabis products? □ Yes □No

_____

Are you currently under the care of a physician? □ Yes □No

If yes, what for? _____

Have you ever been hospitalized? □ Yes □No

If yes, please specify_____

Are you taking any blood thinners such as Aspirin, Coumadin/Warfarin, Heparin, Eliquis, etc.? □ Yes □No

If yes, please specify_____

Has your physician ever told you to take antibiotics prior to dental procedures? □ Yes □No

If so, why? _____

Is there anything else you think we should know regarding you medical history? □ Yes □No

If yes, please describe_____

KING WEST DENTISTRY
Dr. A. Golabchifar & Associates

DENTAL HISTORY

Do you clench or grind your teeth? □ Yes □No

Are there any dental concerns you would like to address? _____

Reason for last Dental Visit: _____

Reason for leaving previous Dentist: _____

OFFICE POLICY

Dental Appointments

We have reserved time with our doctor, assistant and hygienist, as well as operatory space for your upcoming appointment. We have sterilized and prepare the operatory with the necessary equipment and material required for your procedure. We are therefore requiring 48-hours (2-business days) cancellation notice to our office if you are unable to attend and/or need to reschedule your appointment. Cancellation notices must be made by telephone only to one of the administrators. We do not accept text, email or voicemail messages.

Cancellations

If less than **48-hours** (2-business days) **cancellation notice** is provided, or you do not show for your scheduled appointment, a **$75 cancellation fee** will be applied to your account. This cancellation will be used as a deposit toward your next appointment. In the event that you cancel last minute or no show on the second occasion, the $75 cancellation fee/deposit will be forfeited. Please note that insurance companies do not cover fees for broken appointments, therefore payment is your responsibility.

Payments

Unless prior arrangements have been made, payment is due upon completion of treatment. We accept Cash, Interac, MasterCard, Amex or Visa. If there are any outstanding charges on your account, payment is expected in full at the time of your appointment. If full payment is not made, your appointment will be rescheduled until your account is paid. After 60 days interest will be accrued. Please note that not all services may be covered by your insurance carrier and every insurance plan has its own limitations. Our office will do our best to assist you in understanding the details of your insurance plan, however, we are limited in the information we can access due to Ontario privacy laws. It is ultimately your responsibility to understand your insurance plan.

Patient Consent

I have reviewed the above information explained regarding the compliance of appointments and cancellation policy and I accept that fee will be charged to my credit card, if I do not comply.

_____ _____ _____

Credit Card Number **Expiry Date** **CVV**

_____ _____

Signature **Date**

Our team at King West Dentistry look forward to taking care of your oral health needs and welcome you and your family to our team of Dental Professionals!

PATIENT CONSENT FORM: FOR COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office, providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients. In this office Dr. Ali Reza Golabchifar, act as the Privacy Information Officers.

All staff members who come in contact with your personal information are aware of the sensitive nature of information that you have disclosed to us. All staff are trained in the appropriate uses and protection of your personal information.

King West Dentistry is ensuring that:

- Only the necessary information is collected about you,
- We only share your information with your consent,
- Storage, retention, and destruction of your personal information complies with existing legislation and privacy protection protocols,
- Our privacy protocols comply with the privacy legislation standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

**Please be assured that all staff members in our office are committed to ensuring you receive the best quality dental care.*

Consent

I have reviewed the above information explaining how King West Dentistry will use my personal information and the steps your office is taking to protect my information. I am aware that your office has a Privacy Code, and I can ask to review the code at any time. I agree for Dr. Alireza Golabchifar of King West Dentistry to collect, use, and disclose your personal information as set out in the information about the office privacy policies.

_____ _____

Patient Name Signature

_____ _____

Date Witness