625 Park Rd N #1
Brantford, ON N3T 5L8

519-759-7630

❑Mr. ❑Miss ❑Mrs. ❑Ms. ❑Dr. Name:_____ Date of birth: _____
Last First Middle initial day/month/year

Address: _____
Number Street Apt City Province Postal Code

Phone (home): _____ (work): _____ ext:_____Cell: _____

E-mail address:_____

Preferred contact method: ❑Home Phone ❑Cell Phone ❑Work Phone ❑Email ❑Text Message

Person responsible for account: ❑Self ❑Other: _____

Do you have dental benefits? ❑Yes ❑No Insurance Company _____

Previous Dentist:_____ Family Physician: _____

In case of emergency please notify – Name: _____

Relationship: _____ Telephone: _____

How did you hear about Lifetime Dental? _____

MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible dental care.
All information is strictly private and is protected by doctor-patient confidentiality. Please fill in the entire form.

1. Are you in good health?_____ ❑ Yes ❑ No
2. Has there been any change in your general health in the past year?_____ ❑ Yes ❑ No

If yes, please explain:_____

3. Are you currently taking any medication, non-prescription drugs or herbal supplements of any kind? _____❑ Yes ❑ No
   Please specify medications:_____
4. Do you have any allergies? (e.g. penicillin, latex/rubber product)_____❑ Yes ❑ No ❑ Other
   If other please specify: _____
5. Have you ever had a peculiar or adverse reaction to any medicines or injections? _____❑ Yes ❑ No
   If yes, please explain: _____
6. Do you bleed or bruise easily?_____❑ Yes ❑ No
7. Do you have a heart problem of any kind? _____❑ Yes ❑ No
   Explain: _____
8. Have you ever had a heart murmur, mitral valve prolapse or rheumatic fever _____❑ Yes ❑ No
9. Have you ever been advised by your doctor to take antibiotics before dental treatment?_____❑ Yes ❑ No
10. Have you ever been exposed to Hepatitis or Jaundice?_____ ❑ Yes ❑ No

625 Park Rd N #1
Brantford, ON N3T 5L8

519-759-7630

11. Women only: Are you pregnant or breast-feeding?_____ ❑ Yes ❑ No

12. Have you ever been hospitalized for any illness or operations?_____ ❑ Yes ❑ No

Explain: _____

Do you have or have you ever had any of the following? Please check those that apply.

❑ Aids	❑ Epilepsy	❑ Kidney disease	❑ Tuberculosis
❑ Anemia	❑ Excessive bleeding	❑ Liver disease	❑ STD
❑ Arthritis/Rheumatism	❑ Fainting	❑ Lung disease	❑ Osteoporosis
❑ Asthma	❑ Hay fever	❑ Mental disorder	❑ Artifical joint (knee/hip)
❑ Blood Disease	❑ Head injuries	❑ Prosthetic heart valve	❑ Covid 19
❑ Cancer	❑ High/Low blood pressure	❑ Stomach ulcer	
❑ Diabetes	❑ Hip replacement surgery	❑ Stroke	
❑ Dizziness	❑ Knee replacement	❑ Thyroid problem	

Are you currently taking medication for osteoporosis (bisphosphonate)? _____ ❑ Yes ❑ No

Have you ever had any illness not included above? _____ ❑ Yes ❑ No

Specify _____

DENTAL HISTORY

1. Have you ever had a dental examination with a full series of x-rays of your teeth and jaws? _____ ❑ Yes ❑ No

2. When was your last dental visit?_____

3. Have you ever had any complications/problems with past dental treatments?_____ ❑ Yes ❑ No

Please explain _____

4. Have you ever had any problems/reactions to local anaesthetic?_____ ❑ Yes ❑ No

5. Are your teeth sensitive to:

❑ Cold ❑ Sweets ❑ Heat ❑ Other _____

6. Do your gums bleed when: ❑ Brushing ❑ Flossing ❑ Spontaneously

7. Do your gums feel swollen or tender?_____ ❑ Yes ❑ No

8. Does food lodge between your teeth?_____ ❑ Yes ❑ No

9. Does your jaw crack, pop or grate when opened widely?_____ ❑ Yes ❑ No

10. Do you grind or clench your teeth?_____ ❑ Yes ❑ No

11. Reason for today's visit: Examination and cleaning?_____

Emergency or specific problem?_____ Other? _____

625 Park Rd N #1
Brantford, ON N3T 5L8

519-759-7630

Office Policy (please read)

We will help prepare insurance claim forms and assist in requesting reimbursements from insurance companies on behalf of our patients. Not all services may be covered by dental insurance and every plan has its own unique quirks and exceptions. We will do our best to help you clarify your plan. **However, it is the patient's responsibility to understand his or her own dental insurance benefits. Unless otherwise agreed upon, services are to be paid for at each visit as they are performed.**

Please help us in providing the very best of service by remembering that once you have made an appointment this time is reserved for you. Therefore, we require a minimum of **48 hours notice (2 business days)** if an appointment must be cancelled or rescheduled. **A fee may be charged for cancelled or missed appointment without sufficient notice.** Please note that insurance companies do not cover fees for broken appointments. Therefore such fees are the patient's responsibility.

I authorize Lifetime Dental to perform all dental or diagnostic procedures agreed to be necessary or advisable, including x-rays, photographs, and the use of local anaesthetic or other medications as indicated. I understand that if I miss an appointment or provide less than 48 hours notice to cancel or reschedule an appointment, I may be charged a cancellation fee. I assume full responsibility for fees associated with my dental treatment and those of my dependents. I have read and fully understand the above conditions of treatment and I accept my responsibility as a patient at this office.

_____ _____

Signature of patient, parent or guardian — Date

_____ _____

Reviewed by — Date

Privacy Policy

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, and are committed to collecting, using and disclosing information responsibly. In this office, Dr. Chui Kim acts as the Privacy Information Officer. All staff members who come in contact with your personal information are trained in the appropriate use and protection of your information.

Lifetime Dental will ensure that

- Only 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 privacy legislation standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

625 Park Rd N #1
Brantford, ON N3T 5L8

519-759-7630

Lifetime Dental will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and ensure continuous high-quality service.
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you, establish and maintain communication with you (including booking and confirming appointments, treatment follow-up, billing, etc.)
- 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
- To complete and submit dental claims for third party adjudication and payment.
- To comply with legal and regulatory requirements, including the delivery of patient charts and records to the Royal College of Dental Surgeons of Ontario when required, according to the Regulated Health Professions Act
- To deliver charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and
- Quantify damages if any.
- To prepare materials for the Health Professions Appeal and Review Board (HPARB)
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements.
- To comply generally with the law

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, 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. If 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 agree that Lifetime Dental can collect, use, and disclose my personal information as set out above in the information about the office's privacy policies. I know that your office has a Privacy Code, and I can ask to see the Code at any time.

_____ _____

Signature of patient, parent or guardian | Print

_____ _____

Date | Witness Signature