

Patient Information

Patient Name _____ Date _____
Last, First, MI, (Preferred Name)

Gender _____ Family Status _____

Birth Date _____ Age _____
day month year

Address: _____
Street Apartment #

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
Postal Code

• Name of Physician: _____ Phone: _____

Preferred appointment times: Morning Afternoon Evening Any Time M T W T F

Employment Information

Employer Name: _____ Occupation: _____ phone # _____

Responsible Party Information Insurance Information

Party responsible for payment self other _____
relation

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City Province Postal Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City Province Postal Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

List any medications and dosage (including Herbal)

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Neural
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Fainting
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Stroke
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Seizures/Black out | <input type="checkbox"/> High/low Blood Pressure
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Growths/Tumors
<input type="checkbox"/> Radiation treatment | Infectious
<input type="checkbox"/> AIDS/ HIV
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Venereal Disease |
| Pulmonary
<input type="checkbox"/> Asthma
<input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Respiratory problems
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> COPD | Digestive
<input type="checkbox"/> Acid reflux Disease
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Ulcers | Immune
<input type="checkbox"/> Allergies
<input type="checkbox"/> Hay fever
<input type="checkbox"/> Penicillin Allergy reaction _____
<input type="checkbox"/> Latex Allergy reaction _____ | Other
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Thyroid problems |
| Cardiovascular
<input type="checkbox"/> Angina
<input type="checkbox"/> Blood Disease | Neoplastic
<input type="checkbox"/> Cancer | Inflammatory
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Rheumatism | |

Surgeries 1. _____ year 2. _____ year
3. _____ year 4. _____ year

Notes: _____

- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
- Are you pregnant or is it possible you are pregnant _____ due date _____
- Are you now under the care of a physician? Yes No
If yes, please explain: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____
- Do you smoke? How many cigarettes a day? _____ • If you used to smoke, when did you quit? _____
- Do you use recreational drugs? If so, please list which kind. _____
- Do you take antibiotics prior to dental work or surgery? Yes No
- Do you take any medication that thins your blood or affects clotting/bruising? Yes No
- Have you or anyone related to you ever had problems with anesthetic? Yes No
If yes please explain. _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice?

Dental office School

Yellow Pages Work Other _____

Newspaper Walk-by / location Name of person or office referring you to our practice _____

Consent for Services/ Office Agreement

*I understand that my family's appointments are valuable, and that **48 Business** hours must be given if we are unable to attend appointments. A standard appointment time of 30 minutes will incur a fee of \$ 50.00.

*I will be required to **pay for my/my family treatment at each visit**. For treatment involving laboratory work, I will be required to place a deposit for the estimated lab work required (these are separate from Dental office fees).

*I understand that overdue accounts will be charged an Administration Fee of 1.5% per month of the outstanding balance. These charges will be compounded. Outstanding account balances will be passed to a Credit Agency and/or to the Ontario Court System.

*I understand there are premium times in great demand. If I am not attending these premium appointments and thus preventing other patients from making effective use of these times, I will be required to make use of regular hours for treatment.

***My dental insurance plan is a contract between myself and the organization providing me with the coverage.** It is my responsibility to ensure that the treatment I request is covered. However, Lackner Woods Dentistry will help me to the best of their abilities to ensure accurate and timely completion of my insurance forms. Lackner Woods Dentistry has **NO** knowledge of what is covered by my insurance plan. If I have a booklet, Lackner Woods Dentistry will be able to interpret it for me. Many plans require Pre-Determinations to be forwarded for more extensive treatment. Lackner Woods Dentistry will complete these for me. To avoid any delays in receiving my payment from my insurance company I must send my claim immediately, if it is not submitted electronically.

*Lackner Woods Dentistry also understands that your time is valuable we are intent on starting your appointment on time. With the possible exception of short notice emergencies (which all of us might get and we would like to be seen as soon as possible) we will not double book appointments.

* Lackner Woods Dentistry will always make every attempt to see emergency cases promptly.

* Lackner Woods Dentistry will accept Visa, MasterCard, debit or cash.

* Lackner Woods Dentistry will propose my dental treatment with my long-term dental health in mind, and will do their best to give an accurate estimate.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

Signature of Staff, Lackner Woods Dentistry Date: _____

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENT'S PERSONAL INFORMATION

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

This office will collect, 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 assess your health needs and advise you of treatment options
- To enable us to contact you, establish and maintain communication with you
- To offer and provide treatment, care and services in relationship to oral maxillofacial complex and dental care in general
- To communicate with other treating health care providers, including specialists and general dentist who are the referring dentists an/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 efficiently follow-up for treatment, care and billing.
- To complete and submit dental claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records in the Royal College for 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 Royal College of Dental Surgeons in a timely fashion for regulatory and monitoring purposes.
- To permit potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and damages, if any
- To prepare material for the Health Professions Appeal and Review Board (HPARB)
- To invoice for goods and services and process credit card payments.
- To collect unpaid accounts
- To assist this office comply with all regulatory requirements
- To comply generally with the law

By signing the consent 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 for the use and /or disclosure of your personal information, we will seek your approval in advance. Our office has a Privacy Code and you can ask to see it anytime. After reviewing the above information, I agree that, Dr. Sorin Mitrana's Dental Office, can collect, use and disclose personal information about myself, and my family, as set out in the information about office's privacy policies.

Signature

Print Name

Witness

Date

Things Every Insured Patient Needs To Know

Vital Information

- The name of the person in your company who is in charge of employee benefits
- Name of Insurance Carrier & Phone Number

Information patients may be asked to give when calling their insurance company:

1. Name of subscriber
2. Employee's date of birth
3. SIN or Social Security number
4. Employer
5. Policy number
6. Division number
7. Certificate number

Questions Patients Should Ask About Their Insurance

1. What is the annual maximum allowed per patient?
2. What is the anniversary date of the policy? Example: January 1st
3. Is there an annual deductible? If yes, how much is it?
4. Dental benefits are paid on which year's (state/province) Dental Association fee schedule? Example 2005 or 2007.
5. How many units of scaling and/or root planing are covered per year?
Which codes are allowed for these services?
6. How many Recall appointments are allowed annually?
Example: every 3 months, 6 months 9 months?
7. What percentage of coverage is allowed for the following:
 - Diagnostic services
 - Preventive services
 - Restorative services
 - Endodontic services
 - Periodontal services
 - Major treatment . Example crowns, bridges, dentures
 - Treatment Planning / Consultations
8. What is the annual maximum for major treatment?
9. Endodontic and/or Periodontal treatment classified as basic or major treatment?
10. Does the policy offer the ABC clause? (Alternative Benefits Clause)
11. Is nitrous sedation covered under your plan (code 92412)?