Ralhan Dental

Call us today Cornerstone Dental (905) 335-7488 Oak Park Dental (905) 257-3368

Personal Information

Last Name: _____ First Name: _____

Address: _____ City: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____

Cell Phone #: _____ Birth Date (DD/MM/YY): _____ Gender:

Employer/School: _____ Email Address: _____

Referred by: _____ Last Dental Visit: _____

Emergency Contact Name & Relationship: _____ Phone #: _____

Responsible Party

Last Name: _____ First Name: _____ Gender:

Address: _____ City: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____

Employer: _____ Relationship to patient: _____

Primary Insurance

Name of Insured (Last, First): _____ Birth Date (DD/MM/YY): _____ Gender:

Address (if different from above): _____

Insurance Company: _____ ID/Cert #: _____ Group/Policy/Plan #: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance

Name of Insured (Last, First): _____ Birth Date (DD/MM/YY): _____ Gender:

Address (if different from above): _____

Insurance Company: _____ ID/Cert #: _____ Group/Policy/Plan #: _____

Relationship to Patient: _____ Employer: _____

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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. The dentist will review the questions with you. Please complete this form in its entirety.

1. Are you being treated for any medical condition or have you been treated within the past year?

   If Yes, please explain:_____

2. When was your last medical check-up?_____
3. Has there been any change in your general health in the past year?
4. Are you taking any medications, non-prescription drug or herbal supplements?

   If Yes, please list:_____

5. Do you have allergies?

   If Yes, please explain:_____

6. Have you ever had a peculiar or adverse reaction to any medications or injections?

   If Yes, please explain:_____

7. Do you have or have you ever had asthma?
8. Do you have or have you ever had any heart or blood pressure problems?
9. Do you have or have you ever had a heart murmur, mitral valve prolapsed or rheumatic fever?
10. Do you have a prosthetic or artificial joint?
11. Have you ever been advised by your doctor to take antibiotics before dental treatment?
12. Do you have any conditions that could affect your immune system?

    (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)

13. Have you ever had hepatitis, jaundice or liver disease?
14. Have you ever had or have a bleeding disorder?
15. Have you ever been hospitalized for any illness or operations?

    If Yes, please list:_____

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

- ☐ Chest pain, Angina
- ☐ Heart Attack
- ☐ Cancer
- ☐ Hay fever/sinus problems
- ☐ Blood transfusion
- ☐ Tuberculosis
- ☐ Snoring/Sleep Apnea
- ☐ Malignant hyperthermia
- ☐ Mental health problems
- ☐ Drug/alcohol dependency
- ☐ Prosthetic heart valve
- ☐ Seizures
- ☐ Low blood sugar
- ☐ Tumor or Growth
- ☐ Shortness of breath
- ☐ Lung Disease
- ☐ Arthritis
- ☐ Eye disease/Glaucoma
- ☐ Steroid therapy
- ☐ Pacemaker
- ☐ Stroke
- ☐ Kidney disease
- ☐ Contact lenses
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Diet pill therapy
- ☐ Stomach ulcers

17. Are there any conditions or diseases not listed above that you have or have had?
    If Yes, please list: _____
18. Are there any diseases or medical problems that run in your family?
    (e.g. diabetes, cancer, heart disease)
19. Do you smoke or chew tobacco products?
20. Are you nervous during dental treatments?
21. Do you have unhealed injuries, inflamed areas, growths or some spots in or around your mouth?
22. **For women only:** are you pregnant or nursing?
    If pregnant, when is your expected delivery date? _____

I have read and answered the above information/questions to the best of my knowledge, and believe them to be correct. I authorize and request my insurance company to pay directly to Cornerstone Dental otherwise payable to me. I authorize Cornerstone Dental to release any information necessary to secure the payment of benefits. I understand that any balance(s) which may remain is expected at the time of service. As a courtesy to me, I authorize Cornerstone Dental to file all claims electronically.

_____ _____

Patient/Parent/Guardian Signature **Date**

_____ _____

Dentist 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 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. Anil Ralhan acts as the Privacy Information Officer.

All team members who 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.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information about you is collected;
- 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 (RCDSO), and the law.

Do not hesitate to discuss our policies with any member of our office team. Please 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, 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
- To establish and maintain communication with 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 health care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists
- To allow us to maintain communication and contact with you to distribute health care information and book and confirm reservations
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit dental claims for third party adjudication ad payment
- 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 provision of the Regulated Health Professions Act

- 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 regularly and monitoring purposes
- To permit potential purchases, practice brokers and 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
- 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 the 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; we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms on the Regulated Health Professions Acts (RHPA) for the purpose of the RCDSO 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.

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 know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Cornerstone Dental can collect, use and disclose personal information about me as set out above in the information about the office's privacy policies.

_____ _____

Signature **Print Name**

_____ _____

Date **Signature of Witness**

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To Our Patients Who Have Dental Benefits:

We are delighted that you have chosen our office as your partner in oral healthcare! Our goal is to ensure you are offered the best dental health possible. Dental benefits were never meant to provide the best possible care; they are to assist the patient in the treatment of choice.

Your insurance coverage is an agreement between your insurance company and your place of employment. There are many diverse policies and types of coverage. For example, some plans cover as little as 20% of dental procedure cost, while others cover as much as 100%. It is also important to be aware that your coverage may not be based on the current dental fee guide. **The amount of coverage that has been negotiated with your insurance company does not involve the dentist.** Our team will be happy to send your insurance claim electronically or mail it to your insurance company. Your insurance company will in turn send the funds directly into our office, should your policy allow. **The unpaid portion that your insurance plan does not cover is your responsibility.**

- **Your out-of-pocket portion must be paid at each reservation.**
- **You are responsible for any dental procedures no longer covered by your insurance plan.**

Please do not hesitate to ask if you have any questions.

Patient Acknowledgment:

I have read and understand the above statements, and agree to assume full liability for any and all fees not covered by my insurance plan.

_____ _____

Patient/Guardian Signature **Date**

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AUTHORIZATION FORM
Release of Dental Records

Office: _____

_____

_____

_____

_____

Date: _____

Patient's Name: _____

Date of Birth: _____

I authorize the release of any x-rays taken by your office, the duplications of any x-rays received, and answers to any questions our new office has in regards to my previous treatment history.

In doing so, I hereby release your office from all legal responsibility or liability that may arise from this authorization.

Signature of Patient/Guardian: _____

Dr. Anil Ralhan, D.D.S.