Port Credit Dental

OFFICE USE ONLY
Scanned ☐
Initials _____

Date: _____

REGISTRATION FORM

PATIENT INFORMATION		
Last Name: First:		Middle Initial:
Date of Birth: / / D M Y	Age:	☐ M ☐ F ☐ Other Pronoun: _____

Home Phone: _____ Work Phone: _____

Mobile Phone:_____

Street Address: _____

City/Province: _____

Postal Code: _____

Email Address: _____

Do you have dental insurance? ◯ Yes ◯ No
If yes, please give your insurance card to the front desk.

REFERRAL INFORMATION
How did you hear about our office?
Do you have any other family members seen here?

IN CASE OF EMERGENCY PLEASE CONTACT
Name: _____
Relationship to patient: _____
Home Phone Number: _____
Work Phone Number: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for by Visa, MasterCard, Debit or Cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I also understand a $50-$100 cancellation charge will be applied for any missed or cancelled appointments without a 2-business day notice.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date: _____
Signature of Patient or Parent/Guardian

General Release

I, the undersigned, certify that I have provided an accurate and complete 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 regarding my medical-dental history. Should there be any change in either my health status or any other information I have provided, I will advise this dental office. I authorized the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

_____ _____
Signature of: ☐ patient ☐ parent ☐ guardian (Print name of patient/ parent/ guardian)

Reviewed by treating Dentist: _____ Date: _____

Patient Privacy Consent Form

For collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality 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, the Privacy Information Officer is: **Dr. Patricia Kmet**

All staff 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.
In this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected;
- We only share your information with consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with us or any member of our office staff.
Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

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
- 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
- To communicate with other treating health-care providers, including specialists and referring doctors
- 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 billings
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to governing bodies 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 members with governing bodies, including the delivery and/or review of patients' records in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the 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 office'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 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 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) 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 a 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 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 know that your office has a Privacy Code, and I can ask to see the Code at any time.
I agree that this dental office (Port Credit Dental) can collect, use or disclose personal information about:

_____ as set out above in the information
(Patient's Name) about the office's privacy policies.

Signature _____

Print Name _____

(Signature and name above must be of the patient, if 18 years or older, or the legal guardian if patient is younger than 18 years old)