BY THE LAKE DENTAL®
Efficient and effective dental care

Dr. Patricia Khamis-Silva
Dr. Afson Ferdosmakan
Dr. Gloriana Ramirez
Dr. Steve Ma
Dr. Kirill Khromov
Dr. Jonas Stefani
Dr. Ioana Fugariu
Dr. Mona Kumar
Dr. Pooneh Mohebbi

NEW PATIENT FORM

PERSONAL INFORMATION

First Name:		Last Name:	
Date of Birth:		Gender: ( ) Female ( ) Male	
Address:	City	Province	Postal Code
Home Phone:	Cell Phone:	Email:	
Occupation:	Company Name:	Company Phone:	
Emergency Contact:	Relationship:	Phone Number:	
Driver's License:	Health Card:		

All preferred methods of contact:

( ) Home ( ) Work ( ) Text ( ) Mobile ( ) Email	Other:
How did you learn about us or who can we thank for referring you?	
Which languages do you speak?	

BENEFITS INFORMATION

Primacy Policy Holder:

Firsts and Last Name:		Date of Birth:	
Benefit Provider Company	Policy/Contract/Group#	Certificate/ID#	Have you used any of your benefits during your benefit year? ( ) Yes ( ) No

Spousal/Partner Dental Benefits Information (if applicable):

Firsts and Last Name:		Date of Birth:	
Benefit Provider Company	Policy/Contract/Group#	Certificate/ID#	Have you used any of your benefits during your benefit year? ( ) Yes ( ) No

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MEDICAL HISTORY

Your health information is essential to our ability to efficiently and effectively treat your dental requirements. Please complete this information accurately. All personal information is strictly confidential and used exclusively by, By the Lake Dental.

Patient First and Last name:	
Family Doctor:	Phone Number:
Are you being treated for any medical conditions at the present time? ( ) Yes ( ) No	Details: _____

Please check if you have had or have any of the following conditions:

( ) Allergies (Please list):			
( ) Anemia	( ) Emphysema	( ) Hepatitis ( ) A ( ) B ( ) C	( ) Pregnant (months)
( ) Arthritis	( ) Epilepsy	( ) High blood pressure	Prosthetic: ( ) limb ( ) organ
( ) Asthma	( ) Heart attack	( ) HIV related issues	( ) Rheumatic Fever
( ) Bleeding	( ) Heart condition	( ) Kidney issues	( ) Sleep Apnea
( ) Cancer (Please list):			( ) Stomach issues
( ) Chronic bronchitis	( ) Heart Murmur	( ) Liver issues	( ) Stroke
( ) Diabetes	( ) Heart valve surgery	( ) Osteoporosis	( ) Thyroid disease
( ) Smoker How Long? Frequency of use:			( ) Tuberculosis
( ) Cannabis How Long? ( ) Medicinal ( ) Recreational Frequency of use:			
Other conditions (Please list):			

Please list any current medication, including over the counter

_____

_____

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DENTAL HISTORY

My most recent dental visit:	I see my dentist every: ( ) 3 months ( ) 6 months ( ) 12 months ( ) Not routinely
Have you ever had local anesthetic? (Freezing) ( ) Yes ( ) No	Were there any complications? ( ) Yes ( ) No
Have you ever had Botox treatment before? ( ) Yes ( ) No	If yes, what was the reason? ( ) Cosmetic ( ) Therapeutic

Please check if any of the following apply to you:

( ) Bleeding Gums	( ) Unpleasant Taste/ Bad Breath	( ) Frequent Blisters
( ) Swelling/ Lumps in mouth	( ) Ortho Treatment	( ) Difficulty Chewing
( ) Teeth Sensitivity Hot/ Cold	( ) Clicking/ Popping jaw	( ) Clenching Grinding/TMJ
( ) Headaches		

I understand the above information is necessary to provide me with dental care in a safe, efficient and effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my consent to ask the respective health care provider to release such information. I will notify the dentist of any change to my health or medication.

First and Last Name	Relationship to Patient	Signature	Date

INFORMED CONSENT

For the collection, use and disclosure of personal information

We are committed to maintaining the accuracy, confidentially, and security of your personally identifiable information ("Personal Information"). As part of this commitment, our privacy policy governs our actions as they relate to the collection, use and disclosure of Personal Information. Our privacy policy is based upon the values set by the Canadian Standards Association's Model Code for the Protection of Personal Information and Canada's Personal Information Protection and Electronic Documents Act. All **By the Lake Dental** team members are trained in the appropriate uses and protection of your information.

By the Lake Dental will collect, use and disclose your information for the following reasons:

- Email consent for appointment reminders
- Newsletter, promotional material

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- To offer and provide treatment, care and services in relationship to your dental care
- To communicate with other treating health-care providers, specialists and general dentists
- To allow us to maintain communication with you and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- To comply with legal and regulatory requirements in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- To deliver your charts and records to the dentist's benefits carrier to enable the benefits company to access liability and quantify damages
- To process credit card payments and to collect unpaid accounts
- To assist this office to comply with all regulatory requirements and the law

PATIENT CONSENT

I have reviewed the above information that explains how By the Lake Dental will use my personal information, and the steps our office is taking to protect my information. I agree that By the Lake Dental can collect, use and disclose personal information about me as set out above.

First and Last Name	Relationship to Patient	Signature	Date

OFFICE FINANCIAL POLICY & YOUR DENTAL BENEFIT PLAN

At **By the Lake Dental,** we are committed to providing you with efficient and effective dental care. If you have dental benefits, we will support you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

We accept cash, MasterCard, Visa, and Debit. NO CHEQUES OR AMERICAN EXPRESS. Outstanding balances older than 45 days may be subject to finance charges at the monthly rate of 1.5%.

If you have dental benefits, you must bring proof of benefits, so that we can submit your benefit claims and collect information from your benefit provider. However, we are limited to certain information and it is important for you to recognize the following:

1. **Your benefits are a contract between you, your employer, and the benefit company.**
2. **We cannot render services on the assumption charges will be paid for by a benefit company. All charges are your responsibility from the date a dental service is rendered.**

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3. **Not all services may be covered by all benefits contracts.**
4. **Remember to update us regarding any changes to your dental benefit policy, so we may process your claim on your behalf, in a timely manner.**
5. **If you have used any of your benefits at another office, within the same benefit year, you must inform our office. Your benefit maximums will be affected. This information is not provided to us by your benefit provider.**
6. **Claims which have not been paid within 60 days, by your benefit provider, shall be the responsibility of the patient. We will provide you with all and any documentation to support the collection of this claim.**

By the Lake Dental will submit your claim as a courtesy. You are required to pay your patient portion (if there is one) on the day treatment is rendered. **Upon receipt of the benefit payment we will reconcile your account and bill or refund any differences**.

As the dental care provider, we must emphasize, *our relationship is with you, the patient, not your benefits company.* Filing benefits claims is a courtesy we extend to our patients; all chargers are the patient's responsibility, on the date the services are rendered. We realize temporary financial problems may affect the timely payments of your account. If such situations do arise, we request that you contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to support you.

Cancellation Policy:
Please note, your scheduled appointment is time we dedicate for you. We require a minimum of two *(2) business* days advance notice if you need to cancel your scheduled appointment. Please be advised that failure to inform us and repeat of incidents may result in the lost privilege of the option to pre-book appointments.

Initial:

By signing below, I agree to and understand the policies described in this form. I agree to abide by the terms outlined and understand and accept my financial responsibility.

First and Last Name	Relationship to Patient	Signature	Date