
Nancy Castillo


Dr. Monika Kiepas


Dr. David Burman


Gina Arancon-Kovesdi


Luiza Kaci


Susan Ching-Ju Yang

PERSONAL INFORMATION

Title _____ Family Name _____ First Name _____

Date of Birth (dd/mm/yy) _____ Sex: ☐ M ☐ F

Address _____

City _____ Postal code _____

Home phone # _____ Business phone # _____

Who may we thank for referring you? _____

Person to contact in case of emergency:

Name _____ Phone # _____

PLEASE REFER TO MEDICAL QUESTIONNAIRE ON NEXT PAGE

MEDICAL HISTORY QUESTIONNAIRE

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 and explain any that you do not understand. Please provide as much information as you can.

1. Are you being treated for any medical condition at present or have you been treated within the past year? ☐ Yes ☐ No ☐ Not Sure

   Explain: _____

2. When was your last medical checkup?

   _____

3. Are you taking any medications, non-prescription drugs, or herbal supplements of any kind?

   ☐ No

   If yes, please list: _____

   _____

4. What conditions are you taking the medications for? _____

   _____

5. Do you have any allergies? ☐ Yes ☐ No ☐ Not Sure

   If yes, please list, using categories below:

   Medications ☐ _____

   Latex/Rubber Products ☐ _____

   Other (Hay-fever, foods) ☐ _____

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

   ☐ Yes ☐ No ☐ Not Sure

   If yes, please explain: _____

7. Do you have or have you ever had asthma?

   ☐ Yes ☐ No ☐ Not Sure

8. Do you have or have you ever had any heart or blood pressure problem?

   ☐ Yes ☐ No ☐ Not Sure

9. Do you have an artificial heart valve?

   ☐ Yes ☐ No ☐ Not Sure

10. Do you have a prosthetic or artificial joint?

    ☐ Yes ☐ No ☐ Not Sure

11. Have you ever been advised by your doctor to take antibiotics every time you have dental treatment? ☐ Yes ☐ No ☐ Not Sure

12. Do you have any conditions or therapies that could affect your immune system (e.g. Leukemia, AIDS, HIV, radiotherapy, chemotherapy)?

    ☐ Yes ☐ No ☐ Not Sure

13. Have you ever had hepatitis, jaundice or liver disease?
☐ Yes ☐ No ☐ Not Sure

14. Do you have a bleeding problem or blood disorder?
☐ Yes ☐ No ☐ Not Sure

15. Have you ever been hospitalized for any illnesses or operations?
☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

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

☐ Chest Pain	☐ Angina	☐ Shortness of Breath
☐ Pacemaker	☐ Steroid Therapy	☐ Seizures (Epilepsy)
☐ Drug/Alcohol Dependency	☐ Heart Attack	☐ Lung Disease
☐ Kidney Disease	☐ Tuberculosis	☐ Arthritis
☐ Stroke	☐ Prosthetic Heart Valve	☐ Stomach Ulcers
☐ Thyroid Disease	☐ Cancer	☐ Diabetes

17. Are there any conditions or diseases not listed above that you have or have had?
☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

18. Have you ever smoked or chewed tobacco products? ☐ Yes ☐ No

If yes, how many times per day? _____

19. Do you use any cannabis products? ☐ Yes ☐ No

20. Are you nervous during dental treatment? ☐ Yes ☐ No

21. ***For women only:*** Are you breast-feeding or pregnant?
☐ Yes ☐ No ☐ Not Sure

If pregnant, what is expected delivery date? _____

22. Do you identify as a patient with disability? ☐ Yes ☐ No ☐ Not Sure

If yes, please explain: _____

_____

Name of Family Physician: _____

Phone #: _____

Patient or Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

PLEASE REFER TO DENTAL QUESTIONNAIRE ON NEXT PAGE

DENTAL QUESTIONNAIRE

1. Reason for this visit: _____
2. Are you experiencing pain in your teeth or gums? ☐ Yes ☐ No
   If YES, how would you describe the pain?
   ☐ mild ☐ constant ☐ moderate
   ☐ intermittent ☐ severe ☐ spontaneous
   Provoked by:
   ☐ cold ☐ hot ☐ chewing
3. Do you get headaches?
   ☐ often ☐ occasionally ☐ seldom ☐ never
4. Do you experience any of the following problems?
   ☐ bad breath ☐ bleeding gums ☐ loose teeth ☐ joint pain
   ☐ food stuck between teeth ☐ oral habits: nail/pen biting, etc.
   ☐ jaw clicking upon opening/closing your mouth
5. Have you been told that you grind your teeth? ☐ Yes ☐ No
6. Do you wake up in the morning with a feeling of tired jaws? ☐ Yes ☐ No
7. Do you clench your teeth? ☐ Yes ☐ No
8. Do you wear a night guard? ☐ Yes ☐ No
9. How often do you consume acid foods like citrus fruit, juice, pop?
   ☐ daily ☐ _____x a week ☐ occasionally
10. When was your last dental scaling/cleaning _____
11. When were your last dental X-rays taken? _____
12. How often do you usually have dental check-ups? Every:
    ☐ 3-4 months ☐ 6 months ☐ 9 months ☐ less often
13. What kind of toothbrush do you use?
    Manual: ☐ hard ☐ soft
    Electric ☐
14. Do you use mouthwash? ☐ Yes ☐ No
15. How often do you floss? ☐ rarely ☐ _____x a week ☐ daily
16. Have you ever had?
    ☐ fillings ☐ root canal ☐ implants
    ☐ extractions ☐ dentures ☐ gum surgery
    ☐ head trauma ☐ TMJ problem ☐ orthodontic treatment
    ☐ wisdom teeth removal ☐ crowns/bridges
17. Are you satisfied with the color of your teeth? ☐ Yes ☐ No
18. Would you consider sedation for dental treatment? ☐ Yes ☐ No

PAYMENT OPTIONS:

VISA, MASTERCARD, DEBIT, CHEQUES and CASH

WE ACCEPT DIRECT PAYMENTS FROM YOUR DENTAL INSURANCE COMPANY UNDER CERTAIN CONDITIONS:

1. We can verify your coverage details.
2. Policy is **assignable** (payable directly to dentist). Please sign below.

   I hereby assign my benefits, payable from claims submitted electronically to Dr. Monika Kiepas or Dr. David Burman and authorize payment directly to her/him. This authorization shall continue in effective until the undersigned revokes the same.

   Patient Signature: _____
3. You provide us with a credit card to be used for all expenses not covered by your dental insurance.

   For your convenience we offer deferred payment plans. Please inquire at front desk.

We use EDI. We do (on your request) submit insurance claims electronically to your insurance provider.

Patient Signature: _____ Date: _____

ELECTRONIC COMMUNICATION

We send emails to remind patients about future appointments, book and confirm appointments, verify insurance information. We require your consent to use this form of communication. You can revoke your consent at any time.

Do you consent to receiving electronic communication from Dental Care Centre?

☐ Yes, email address: _____ ☐ No

Patient Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

DENTAL CARE CENTRE

Dr. Monika Kiepas & Dr. David Burman

81 St. Clair Avenue East, Toronto, Ontario, M4T 1M7 Phone: (416) 961-8778 Fax: (416) 961-5776

DENTAL CARE CENTRE

PERMISSION TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

Our office understands the importance of protecting your personal information.

We will collect, use and disclose your personal information only for appropriate purposes:

1. To diagnose and provide health care.
2. To communicate with you and your other health care professionals.
3. For scheduling and billing purposes, including completion of dental claim forms.
4. To comply with legal requirements of the RCDS of Ontario, provincial regulations, and to generally comply with the law.
5. For audit and evaluation of the dental practice.
6. To provide an invoice, process credit or debit card payments, and to collect unpaid accounts.

If a new purpose would arise for the use and disclosure of your personal information, we will seek your approval in advance. We will not under any conditions supply your insurer with your confidential medical history, without your specific consent. If unusual requests are received, we will contact you for permission prior to releasing such information. You may withdraw your consent for use of disclosure of your personal information, and we will explain the ramifications of that decision. In this office, any Doctor may act as the Privacy Information Officer. Do not hesitate to discuss our policies with any member of our office staff.

Patient Consent

I have reviewed the above information that explains how this office will use my personal information, and the steps taken 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 DENTAL CARE CENTRE can collect, use and disclose personal information about _____ as set out in the above privacy policies.

Print Name_____Signature_____

Date_____Witness_____