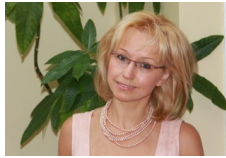




Nancy Castillo



Dr. Monika Kiepas



Dr. David Burman



Gina Arancon-Kovesdi



Luiza Kaci



Susan Ching-Ju Yang

PERSONAL INFORMATION

Family Name _____ First Name _____

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

Father's Name _____ Date of Birth (dd/mm/yy) _____

Mother's Name _____ Date of Birth (dd/mm/yy) _____

Address _____

City _____ Postal code _____

Home phone # _____ Business phone # Father's: _____

Mother's: _____

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:
- | | | |
|--------------------------------------------------|-------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Angina | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Steroid Therapy | <input type="checkbox"/> Seizures (Epilepsy) |
| <input type="checkbox"/> Drug/Alcohol Dependency | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Prosthetic Heart Valve | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | |

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. Are you nervous during dental treatment? Yes No

Name of Family Physician: _____	
Phone #: _____	
Parent's Signature: _____	Date: _____

Dentist Signature: _____	Date: _____
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PLEASE REFER TO DENTAL QUESTIONNAIRE ON NEXT PAGE

DENTAL QUESTIONNAIRE

1. Reason for this visit: _____
2. Age: _____ years _____ months
3. Last dental visit _____, dental X-rays _____
4. How often does your child usually have dental check-ups? Every:
 3-4 months 6 months 9 months less often
5. What kind of toothbrush does your child use?
Manual: hard soft
Electric
6. Does your use any mouthwash? Yes No
7. How often does your child floss? rarely _____x a week daily
8. *Please choose one of the following:*
 I brush my child's teeth
 My child brushes teeth under my supervision
 My child brushes teeth unattended
 I let my child brush and then I brush his/her teeth myself
9. Has your child ever had?
 fillings root canal extractions
 head trauma TMJ problem orthodontic treatment
10. Is your child involved in any contact sports? Yes No
11. Does your child wear a protective mouthguard? Yes No N/A
12. Does your child have any of the following oral habits?
 sucking pacifier sucking fingers biting pens, nails
 grinding teeth at night snoring
13. What does your child usually drink?
 tap water juice milk
 bottled water pop chocolate milk
14. How often does your child have sweets? never _____x a day _____x a week

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.

Policy holder: _____

Policy holder's 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.

Parent's 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

Parent's 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 or 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 _____