City South dental

PATIENT INFORMATION AND MEDICAL HISTORY FORM

Patient Name	**Date of Birth**	**Phone**
Home Address	**Email**	**Family Doctor**
Emergency contact	**Relationship**	**Phone**

General health estimate: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Most Recent Physical Exam: _____

Do you have or have you ever had any of the following? Check Y (Yes) or N (No) and provide brief details where indicated.

	Y	N
Hospitalization for illness/injury, or a serious ongoing health condition	☐	☐
Allergic/adverse reaction to medication, anesthetic, latex, or food (list): _____	☐	☐
Heart problems, cardiac stent, murmur, rheumatic fever, or artificial/repaired heart valve (PFO)	☐	☐
Pacemaker, defibrillator, or history of infective endocarditis	☐	☐
High or low blood pressure	☐	☐
Stroke, taking blood thinners, anemia, or a bleeding/clotting disorder (INR > 3.5)	☐	☐
Orthopedic or soft-tissue implant (e.g., joint replacement, breast implant)	☐	☐
Kidney disease, or liver disease/jaundice	☐	☐
Thyroid, parathyroid, or calcium-related disorder	☐	☐
Diabetes (HbA1c: _____)	☐	☐
Stomach/duodenal ulcer, or digestive/eating disorder (celiac, reflux, bulimia, anorexia)	☐	☐
High cholesterol, or taking statin drugs	☐	☐
Osteoporosis/osteopenia, or ever taken anti-resorptive medication (e.g., bisphosphonates)	☐	☐
Arthritis, gout, or autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	☐	☐
Glaucoma, or wear contact lenses	☐	☐
Head or neck injuries	☐	☐
Epilepsy or convulsions (seizures)	☐	☐

	Y	N
Neurologic disorder (ADD/ADHD, prion disease), or concentration/ADHD diagnosis	☐	☐
Viral infections/cold sores, or lumps/swelling in the mouth	☐	☐
Hives, skin rash, hay fever, or STI/STD/HPV	☐	☐
Hepatitis (type _____), or HIV/AIDS	☐	☐
Tumor/abnormal growth, or history of radiation therapy	☐	☐
Chemotherapy, or immunosuppressive medication	☐	☐
Emotional difficulties, psychiatric treatment, or antidepressant medication	☐	☐
Sleep problems (apnea, snoring, insomnia, restless sleep, bedwetting)	☐	☐
Breathing problems (asthma, sinus congestion), pneumonia/emphysema, or TB/measles/chicken pox	☐	☐
Smoker or previously smoked/used smokeless tobacco; alcohol or recreational drug use	☐	☐
Speech difficulties or delayed growth at any time	☐	☐
Presently under treatment for an illness, or a change in your health in the last 24 hrs (fever, chills, cough, diarrhea)	☐	☐
Taking medication for weight management, dietary supplements, or birth control pills	☐	☐
Currently pregnant, or diagnosed with a prostate disorder	☐	☐
Often exhausted/fatigued, or experiencing frequent headaches/chronic pain	☐	☐
Consider yourself a touchy/sensitive person, or often unhappy/depressed	☐	☐

Describe any current medical treatment, impending surgery, genetic/developmental delay, or other treatment that may affect your dental treatment (e.g., Botox, collagen injections):

List all medications, supplements, and/or vitamins taken within the last two years:

Drug	Purpose	Drug	Purpose

Patient Consent Form: Collection, Use and Disclosure of Personal Health Information

Privacy Notice & Patient Consent

City South Dental protects your personal health information (PHI) in accordance with Ontario's **PHIPA**, RCDSO standards, and ODA guidance. **Dr. Rajvinder Bhatia** is the office Privacy Officer and can answer privacy-related questions. With your consent, we may collect, use, and disclose your PHI to provide and coordinate dental care, communicate with health-care providers involved in your care, manage appointments, treatment, billing, and insurance claims, meet legal and regulatory requirements, support education, quality improvement, or practice transfer where legally permitted.

Any new purpose will require your consent unless otherwise permitted or required by law.

You can request access to or correction of your dental records, withdraw or restrict consent, subject to legal record-retention requirements, raise privacy concerns with our Privacy Officer or the Information and Privacy Commissioner of Ontario (IPC).

Privacy & Technology

We will notify you of privacy breaches as required by law. Express consent will be obtained before recording appointments or virtual consultations. If AI-assisted technology is used in your care, you will be informed and consent will be obtained as required.

Safeguards

Your records are securely stored, retained, and destroyed according to PHIPA, RCDSO requirements, and office privacy policies. Access is limited to authorized staff.

Refund Policy

Once treatment has been rendered with your consent, **no refunds can be processed**.

Patient Consent

I have reviewed and understand how City South Dental collects, uses, and discloses my personal health information and how it is protected. I understand that I may request a copy of the office Privacy Code at any time.

I consent to City South Dental collecting, using, and disclosing personal health information about _____ in accordance with the above information and the office's privacy policies.

Patient/Guardian Signature: _____ Date: _____

INFORMED PATIENT CONSENT FOR DENTAL TREATMENT

Patient Name: _____

Date of Birth: _____ Age: _____

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1. Purpose of This Consent

I, _____ (print name), acknowledge that I have been informed about the nature, purpose, benefits, risks, and alternatives of the recommended dental treatment(s). I understand that I have the right to accept or refuse any proposed treatment.

I confirm that I have had the opportunity to ask questions and that all my questions have been answered to my satisfaction.

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2. Authorization for Treatment

I hereby authorize **Dr. Bhatia and Associates** and their designated staff to perform dental procedures as deemed necessary or advisable, including but not limited to:

- Dental examinations and radiographs (X-rays)
- Preventive services (cleaning, fluoride, scaling)
- Restorations (fillings)
- Crowns, bridges, veneers
- Root canal therapy
- Periodontal (gum) treatment
- Extractions
- Dentures or prosthetics
- Oral surgery (if required)
- Implant treatment (if required)

I understand that some procedures may require additional specific consent forms.

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3. Local Anesthesia

I understand that local anesthesia may be used during treatment. I have been informed that although rare, potential risks include:

- Temporary or, in very rare cases, permanent numbness of the lip, tongue, or surrounding tissues
- Allergic reactions
- Bruising or soreness at the injection site

I consent to the use of local anesthesia if deemed necessary.

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4. Patient Responsibilities

I understand that the success of my dental treatment depends on my cooperation, including:

- Attending scheduled appointments
- Following pre- and post-treatment instructions
- Maintaining proper oral hygiene
- Taking prescribed medications as directed
- Informing the dentist of any changes in my medical history

I understand that failure to follow these instructions may negatively affect treatment outcomes.

5. Risks of Dental Treatment

I understand that all dental procedures carry potential risks, which may include (but are not limited to):

- Pain, swelling, or discomfort
- Infection or delayed healing
- Bleeding
- Damage to adjacent teeth or restorations
- Temporary or permanent nerve injury
- Jaw fracture (rare)
- Sinus complications (for upper teeth procedures)
- Possible need for additional treatment

I acknowledge that complications may occur despite careful treatment.

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6. If I Decline Treatment

I understand that refusing or delaying treatment may result in:

- Worsening dental condition
- Increased pain or infection
- Tooth loss
- Bone loss
- Gum disease progression
- Possible impact on overall health

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7. Financial Agreement

I understand that:

- I am responsible for all fees related to my dental treatment, regardless of insurance coverage.
- City South Dental may submit claims to my insurance provider on my behalf.
- Any portion not covered by insurance remains my responsibility.

I authorize City South Dental to communicate with my insurance provider as needed.

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8. Communication Consent

I authorize City South Dental to contact me via:

☐ Phone
☐ Text Message
☐ Email

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9. Accuracy of Information

I certify that all medical and personal information I have provided to City South Dental is accurate to the best of my knowledge.

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10. Acknowledgment and Consent

By signing below, I confirm that:

- I have read and understood this document
- I have had the opportunity to ask questions
- I voluntarily consent to the recommended dental treatment

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If Patient is Under 18:

I, _____ (parent/guardian), authorize treatment for:

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

PATIENT INSURANCE DETAILS

We require pre-signed dental claim forms with DUAL insurance coverage.

Primary Insurance: No____Yes_____Ins.Co.:_____

Name of Insured: _____Birth Date: ____/___/_____

Group/Policy #:_____ID#: _____

Dual Insurance: No_____Yes_____Ins.Co.:_____

Name of Insured: _____Birth Date: ____/___/_____

Group/Policy #:_____ID#: _____

Please note, you should declare if you have any second/dual/alternate insurance to ensure that your visit is covered. Insurance companies take -5-10 business days to assess estimate. Failure to declare might cause you to pay the difference of what first insurance has paid. We will give a receipt of your payment which can be used to claim what you paid.

As a new patient of ***CITY SOUTH DENTAL OFFICE***, we welcome you & your family to a dental practice dedicated to maintaining your oral health. This office is equipped with modern dental equipment operated by highly trained dentists and staff.

This office meets or exceeds all government required standards for sterilization. This is yet another way we strive to assure your continued comfort and health.

The Canadian Dental Association, in conjunction with provincial associations, insurance carriers, network suppliers and dental system vendors, has established a network that allows us to submit claims and pretreatment plans electronically. This network is called CDAnet. We shall send claims and predeterminations using CDA net.

I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.

Signature of patient/guardian _____

As a COURTESY to our patients, we will complete all dental insurance claim forms & submit them on behalf of our patients, electronically, by courier or by mail, (provided the plan administrator's authorization is not required), assignment will be accepted for most plans.

Please complete the following:

I hereby assign my benefits payable from claims submitted electronically or manually to my dentist at City South Dental Office and authorize payment directly to the dental office.

Signature of patient/guardian, subscriber _____

DECLARATION

Has an initial exam been charged to your current insurance policy within the past 3 years? ( )yes ( )no

Has a full series or panorex x-ray been taken within 3 years? ( )yes ( )no

I fully understand and agree that should my insurance not pay 100% of my dental costs, I accept FULL RESPONSIBILITY to pay the balance in full.

I have no insurance coverage at this time and do agree to make payments in full by cash, debit or credit card payment on completion of each scheduled appointment, unless other arrangements are made with the Manager or Dentist PRIOR to treatment.

I authorize Dr Rajvinder Bhatia and the staff of City South Dental Office to send correspondence to me via email.

TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION I HAVE PROVIDED IS CORRECT.

_____Date: _____

Signature of patient, parent/guardian

Occasionally appointments are cancelled with less than 24 hours notice. This leaves us with openings that are impossible to schedule. While we do attempt to remind our patients of their appointments, this is only a COURTESY which at times may be impossible to provide. We require 48 hours of notice of cancellation. Failure to do so may necessitate a charge of **$250.00** to your account.