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| **PATIENT MEDICAL QUESTIONAIRE**   1. Physician name, number and address (and/or specialist) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Are you taking any medication including vitamins & herbal? Yes No   If so, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you ever had any reactions to any drugs or medications Yes No   If so, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do you have any allergies? Yes No   If so, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you ever been hospitalized? Yes No   If so, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do you bruise easily or bleed abnormally? Yes No   If so, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you ever had heart disease or heart murmur? Yes No   If so, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do you experience shortness of breath? Yes No   If so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do you smoke tobacco or any other controlled substances? Yes No   If so, qty\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you ever had radiation treatment or chemotherapy? Yes No   If so, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Have you ever taken cortisone? Yes No   If so, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Do your ankles swell during the day? Yes No   **For women only**: are you pregnant? Yes No  **Do you have or have had any of the following? (Please circle)**  Heart trouble Liver disease Asthma Hepatitis  High blood pressure Epilepsy Blood disorder Herpes  Rheumatic fever Thyroid problems Anemia Cancer  Kidney disease Tuberculosis HIV/AIDS Diabetes  Joint replacement Stroke Other Specify below  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  This is to certify that I, the undersigned, consent to the performing of, the dental oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated and the use of personal information in accordance of the Office Privacy Policy (see over), and I will assume responsibility for fees associated with these procedures.  Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of caregiver/guardian if under the age of 18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | How did you hear about our office?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Were on Facebook: Passage Community Dental  facebook.jpg  Insurance Coverage  Insurance Maximum? Basic & Major?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What Percentage does your plan cover?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many units of scaling are you covered per year?  (Code 11111)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many units of root planning am I covered per yer?(Code 43421)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How many units of polish are you covered per year? (Code 11101) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Am I covered for fluoride?(Code 12101)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Am I covered for desensitization?(41301) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Am I covered for Oral Hygiene Ints (Code 13211)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Am I covered for Perio Exam (Code 01501)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Am I covered for a Pan (Code 02601)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Am I covered for Bitewings (02144/02142) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(How often\_\_\_\_\_) |
| |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Mr. Mrs.  Miss. Ms. Mstr | Last Name | | | | | First Name | | | | |  | | Circle one  **M/F** | Email &/or cell | | | | | | | | | |  | | Address | | | | | | | | | | |  | | City | | | | Province | | | | | Postal Code | | | Residence Phone  ( ) | | | Business Phone  ( ) | | | | | | Date of Birth  M/ Day/ Yr./ | | | Emergency Contact:  Name: Address: | | | | | Phone Number(s) Different from above: | | | | | | | Employer/Policy Holder | | Health Card Number /Exp date | | | | | | | Do you have Dental Insurance? | | | Yes | No | | Insurance Company Name  1.  2. | | Ins Group/Policy Number  1.  2. | | | | | | | Subscriber   * Spouse * Parent | | | Certificate/ID Number  1.  2. | | | | | | | | Subscribers Name and Address if different than patient  1.  2. | | | | | | | Subscribers Date of Birth  1.  2 | | | | | **Credit Card : Visa or Mastercard**  **Credit Card Number: Exp: V-Code:**  **I authorize Dr Janice Lowe to apply any balances to my credit card if they have been outstanding for a period of 60 days or longer.** | | | | | | | | | | | | I authorize release, to my dental benefits plan administrator and the Canadian Dental Association (CDA), information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes the same**.**   Cancellation Policy - Please read carefully We require 48 hours notice (excluding weekends) to cancel or change your scheduled appointment; otherwise a fee of $55.00 per half-hour will be charged to your account. | | | | | | | | | | | | Signature of patient, parent or guardian | | | | | | | | Date | | | |  | | | | | | | | | | | |  | **Privacy Policy**  ***Our commitment to our patients is to protect private and personal information that you disclose to our office.***  **Collection and Use of your Personal and Private Information**  We collect personal information, such as, medical history, name, address, email address, contact information, birth date, dental insurance policy/plan & identification numbers, which may include, but not limited to your social insurance number, employer & occupation information and previously recorded dental history. We collect and use this information for proper dental health management and to access dental insurance information to provide direct billing services to you.  **Disclosure of your personal information**   * We do not sell or share our information about our patients to others. Your personal information is a vital part of our on-going dental health relationship with you. We will only disclose personal information on a confidential basis; * To our dental colleagues, in consultation while determining a diagnosis; * in the event of a life threatening or security emergency (the individual will be notified of the disclosure); * for statistical or scholarly study or research (the Privacy Commission must be notified prior to this use.); * to a specialist, in an attempt to rectify or properly diagnose a dental health issue; * to dental professional auxiliary staff (required information only) to schedule a referral appointment for a dental health issue; * to your insurance provider (required information only) to determine your dental benefits; * to complete a task/transaction initiated by you; * to credit rating organizations to ensure financial preparedness; * to prevent or reduce the risk of fraud; * to a lawyer representing the dental practice; * if required or permitted by law; or if you request or consent to the disclosure.   **Protection and Security**  The offices of Dr. Janice Lowe Dental Services Inc. locations, Eastern Passage, provide appropriate physical, technological and organizational measures to safeguard personal information and to protect it from unauthorized use, access, deletion and/or alternation. This includes limited disclosure to other dental providers who may have a dental health related reason to know this personal information.  If you have any questions concern or require more detailed information, please contact us by sending an email request to: passagedental@bellaliant.com or call:  **Privacy Officer/Dr. Janice Lowe Dental Services Inc.**  **902-461-1178** |
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