Dr. Ahmed Sharaf, D.D.S

www.udental.ca email:u@udental.ca

U DENTAL

1537 Merivale Road, Unit 1
Ottawa, ON K2G 3J3
T: 613.228.3000 F: 613.228.3080

CONTACT INFORMATION

Name: _____ Preferred Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Birthday: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Can we contact you by email? ☐ Yes ☐ No

How did you hear about us? _____

MEDICAL HISTORY

To ensure that we provide you with the best treatment possible, please complete the medical questionnaire below.

Physicians Name: _____ Date of last physical exam: _____

Are you or could you be pregnant? ☐ Yes ☐ No Are you nursing an infant? ☐ Yes ☐ No

Please check off any of the following conditions that you have or had in the past.
There is a space on the following page for any conditions you may have that are not specified below.

- ☐ High Blood Pressure
- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Irregular Heartbeat
- ☐ Heart Failure
- ☐ Damaged Heart Valve
- ☐ High Cholesterol
- ☐ Heart Infection
- ☐ Stroke

- ☐ Anemia
- ☐ Sickle Cell Anemia
- ☐ Bleeding Disorder

- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Emphysema/Bronchitis
- ☐ Difficulty Breathing

- ☐ HIV/AIDS positive

- ☐ Diabetes
- ☐ Thyroid Condition

- ☐ Dialysis
- ☐ Kidney Disorder

- ☐ Delayed Healing
- ☐ Past use of Steroids

- ☐ Sexually Transmitted Infection

- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Osteoporosis

- ☐ Glaucoma

- ☐ Impaired Vision
- ☐ Impaired Hearing
- ☐ Learning Disorder
- ☐ Fainting

- ☐ Acid Reflux
- ☐ Irritable Bowel Syndrome
- ☐ Stomach Ulcer
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Hepatitis

- ☐ Bipolar Disease
- ☐ Depression
- ☐ Anxiety

- ☐ Sleep Disorder
- ☐ Dementia

- ☐ Epilepsy/Seizures
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Headaches

- ☐ Hives/Skin rash

- ☐ Eating Disorder

- ☐ Tobacco Use
- ☐ Recreational Drug use
- ☐ Alcohol Use
- ☐ Chemical Dependency

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MEDICAL HISTORY

Please list any condition, disease, or problem that was not listed on the previous page.

Please explain any surgeries or times you have been hospitalized.

Please list any prescription and non-prescription medications that you are taking and why.

ALLERGIES

- ☐ Local Anesthetic
- ☐ Acetaminophen
- ☐ Latex
- ☐ Sulfa
- ☐ Antibiotics
- ☐ Codeine
- ☐ Narcotics
- ☐ Other: _____
- ☐ Aspirin/Ibuprofen
- ☐ Metals
- ☐ Penicillin

DENTAL HISTORY

When was your last dental checkup? _____

When was your last dental cleaning? _____

Do you brush your teeth? ☐ Yes ☐ No How often? _____

Do you floss? ☐ Yes ☐ No How often? _____

Do your gums bleed when you brush or floss? ☐ Yes ☐ No Specify: _____

Do your gums feel tender or swollen? ☐ Yes ☐ No

Do you have bad breath or a bad taste in your mouth? ☐ Yes ☐ No

Do you clench or grind? ☐ Yes ☐ No Does your jaw crack, pop, or click when opening? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Have you ever had local anesthetic? ☐ Yes ☐ No Were there ever any complications? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No How long have you been using tobacco? _____

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CONSENT FORM

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I haven't knowingly omitted data.

I authorized this dental office to perform diagnostic procedures as may be required to determine necessary treatment.

Patient Name _____ Signature _____

Privacy Policy:

Privacy of your personal information is an important part of our office. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle you personal information.

In this office, Dr. Ahmed Sharaf acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you provide to us. They are all trained in the appropriate use and protection of your information.

Our office is taking every measure possible to ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols
- Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professionals Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue. Our office will not under any conditions supply your insurer with your confidential medical history. In the even that this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

If usual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is appropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the details associated with this decision and the process.

I have reviewed the above information that explains how U Dental will use my personal information and the steps U Dental is taking to protect my information. I agree that U Dental can collect, use, and disclose my personal information as set out in the Privacy Policy.

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INSURANCE AND PAYMENT POLICY

Welcome to U Dental. On your first visit here, we will require that you pay in full for treatment provided that day, regardless of insurance coverage. If you have insurance, we will submit your claim for you and your insurance company will compensate you.

For future visits, we can bill your insurance company for minor and major treatments. You will then be required to pay the remaining balance not covered by your insurance at the time of treatment. We accept payment by Visa, MasterCard, Debit, or cash. Please note that we do not accept personal cheques. If there is a balance on the account for more than 30 days, the patient is responsible for payment of the balance regardless of insurance coverage. **The patient is responsible for all outstanding balances regardless of insurance coverage**.

Please note that in all major treatment situations like crowns, bridges, implants, dentures, or any other procedure requiring laboratory work, a deposit of 50% is required prior to treatment.

It is the patient's responsibility to provide the proper contract and subscriber ID numbers, and the policy information.
It is also the patient's responsibility to know and understand the coverage and limitations of their insurance plan.
This includes: percentage covered for minor and major treatment, maximum covered per year, start date of coverage (ex: calendar year vs. rolling plan), deductibles

U Dental does not take responsibility if the cost of treatment goes above the maximum payable by insurance. It is the responsibility of the patient to keep track of the amount that has been paid by insurance and how much money is remaining on their insurance plan prior to each appointment. The patient is required to pay for all treatment and fees not covered by their insurance.

Consent:

I understand and accept the insurance and payment policy outlined above. I authorized the release, to my dental benefits plan administrator and CDA, information contained in claims submitted electronically. This authorization shall continue in effect until the undersigned revokes the same. I hereby assign my benefits, payable from claims submitted electronically to U Dental and authorize payment directly to the dentist. This authorization shall continue in effect until the undersigned revokes the same.

Patient Name	Signature	Date

CODE OF CONDUCT POLICY

We are pleased to serve you politely and competently. Within our mission statement, our staff is very pleased to serve you in a polite courteous manner, and thus this level of behaviour is expected in return. It is the responsibility of both patient and staff to conduct oneself in nothing but professional and polite mannerisms. There is a low tolerance level in place for anything but, which could result in dismissal.

FOR OFFICE USE ONLY

NOTES:

Dentist Name	Signature	Date