DR. URSZULA BARRIOS
www.guelphdentist.com
824 Gordon Street Guelph, Ontario N1G 1Y7
519-767-6453

PATIENT INFORMATION

Date: _____ ☐ New Patient ☐ Update

Patient: _____ _____ _____

Last First MI Preferred Title

☐ Male ☐ Female ☐ Child* ☐ Student** ☐ Single ☐ Married ☐ Divorce ☐ Widowed

*If child provide parent/guardian name(s) below:

_____
Parent/Guardian Name(s)

*If Student, Please complete: ☐ Full-time ☐ Part-time

_____
School/Location

Patient Date of Birth: _____ Patient SSN: _____

Address: _____

_____

_____

City St. Zip Code

Email: _____

Home: _____

Cell: _____

Other: _____

Pager: _____

Fax: _____

Referral? ☐ Yes ☐ No Referred By: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

_____ Tel: _____
Name Relationship

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____

_____

_____

City St. Zip Code

Email: _____

Work: _____

Direct: _____

Other: _____

Pager: _____

Fax: _____

Email: _____

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INSURANCE INFORMATION

Subscriber: _____

Last First MI Preferred Tittle

Subscriber Date of Birth: _____ Subscriber SSN _____

Subscriber Employer: _____

Patient Relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Insurance Carrier: _____

Group/Policy No.: _____ ID No.: _____

Address: _____ Tel.: _____

_____ Toll Free: _____

_____ Fax: _____

City St. Zip Code

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Medical History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

☐ Y ☐ N Under a Physician's care now?
☐ Y ☐ N Any Hospitalization in the past 5 years? _____
☐ Y ☐ N Any serious illnesses/surgeries? _____
☐ Y ☐ N Use tobacco in any form? If yes, Type: _____
☐ Y ☐ N Is pre-medication required before dental visit due to heart condition or artificial joint?
☐ Y ☐ N Taking any prescription or daily OTC medication/Drugs? If yes, list details in the Medication Section.

Female Patients: ☐ Y ☐ N Currently Nursing? ☐ Y ☐ N Currently Pregnant Due Date _____

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N If yes, please describe:

_____

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

All patients: Do you have, or have you ever had any of the following? (Check all that apply) ☐ **NONE**

☐ Acid Reflux	☐ Bulimia	☐ Hearing Problems	☐ Psychiatric Treatment
☐ ADHD	☐ Cancer/Malignancy	☐ Heart Attack	☐ Radiation/Chemo
☐ AIDS/HIV	☐ Cerebral Palsy	☐ Heart Disease	☐ Respiratory Disease
☐ Anemia	☐ Chemical Dependency	☐ Heart Murmur	☐ Rheumatic Fever
☐ Anorexia	☐ Chicken Pox	☐ Hepatitis	☐ Sinus Problems
☐ Anxiety	☐ Convulsion	☐ High Blood Pressure	☐ Stroke
☐ Artificial heart valve	☐ Depression	☐ Kidney Disease	☐ Thyroid Condition
☐ Artificial Joints	☐ Diabetes	☐ Lever Problems	☐ Tuberculosis
☐ Arthritis	☐ Dizziness/Fainting	☐ Mitral Valve Prolapse	☐ Ulcer
☐ Asthma	☐ Epilepsy/ Seizures	☐ Mononucleosis	☐ Venereal Disease
☐ Autism/Asperger's	☐ Frequent Ear Infections	☐ Pacemaker	
☐ Bleeding disorder	☐ Frequent Headaches	☐ Other Please list: _____	

All patients: Are you Allergic to or have you ever had any reaction to the following? (Check all that apply) ☐ **NONE**

☐ Aspirin	☐ Codeine	☐ Lactose Intolerance	☐ Sleeping Pills
☐ Anesthetic – Local	☐ Dairy	☐ Mental Sensitivity	☐ Sulfa Drugs
☐ Barbiturates	☐ Latex	☐ Nitrous Oxide Sedation	☐ Penicillin/ other Antibiotics

☐ Other Please List _____

Medical History

All patients: are you currently taking any of the following? (Check all that apply): ☐ **NONE**

☐ Antibiotics/Sulfa Drugs	☐ Antihistamines/allergy	☐ Daily Aspirin	☐ Blood Pressure Medications
☐ Blood Thinner	☐ Cancer/Chemo Medications	☐ Cortisone/Steroids	☐ Heart Medication/ Digitalis
☐ Insulin	☐ Nitroglycerin	☐ Oral Contraceptives	☐ Osteoporosis Medication
☐ Other Diabetic medications	☐ Recreational Drugs	☐ Thyroid Medications	☐ Tranquilizer

☐ Other (please list below)

Drug Name	Dosage	Reason Prescribe

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Previous Dentist Information

Dentist: _____ Telephone: _____

Clinic/ Facility: _____

Address: _____

_____

_____

City St. ZIP code

Reason for changing: _____

Dental History

Oral Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last dental visit: _____ Treatment Type: _____

*Note: Some insurance plans do not cover this service; Please check your plan documents for details.

☐ Y ☐ N Are you currently having dental discomfort? If yes, explain: _____

☐ Y ☐ N Any unhappy/unpleasant dental experience?If yes, explain: _____

☐ Y ☐ N Any injuries to mouth/teeth/head?If yes, explain: _____

☐ Y ☐ N Any missing teeth other than wisdom teeth or orthodontics extractions?

☐ Y ☐ N Have missing teeth been replace?

☐ Y ☐ N Orthodontics appliances now or in the past?

☐ Y ☐ N Gums bleed when brushing or flossing?

☐ Y ☐ N Concerned about gum disease? History of gum disease? ☐ Y ☐ N

☐ Y ☐ N Any concern about the appearance of your teeth?

☐ Y ☐ N Does it hurts bite or chew?

☐ Y ☐ N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐ Y ☐ N

☐ Y ☐ N Do you become a regular continuing care patient in our practice?

☐ Y ☐ N Do you want your mouth properly restored and pain free?

☐ Y ☐ N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concern/comments?

_____

Child/Minor patients: Please answer the following questions:

☐ Y ☐ N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐ Y ☐ N Any unusual speech habits? If yes, explain? _____

☐ Y ☐ N Any lost teeth? If yes, List _____

☐ Y ☐ N Does the patient receive assistance with brushing and flossing? If yes, how often? _____

Primary Physician information

Physician: _____ Telephone: _____

Clinic facility: _____

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Acknowledgement of Privacy Practices

Update 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996(HPAA). I understand the term in which my personal health and identification information may be used.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that my request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation and I understand that you are required to agree my requested restrictions, but if you do agree the you are bound to abide by such restrictions.

Signature _____ Date: _____

Relationship to patient ☐ Adult Patient ☐ Parent ☐ Guardian ☐ Other

Please list any dependent children under the age of 18 also covered by this acknowledgement:

☐ I give permission for the following communications.

- ☐ Cell phone ☐ Text Message Reminders
- ☐ Home phone ☐ Work ☐ E-mail

☐ I am Granting permission for Dr. Urszula Barrios DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am Granting permission for Dr. Urszula Barrios DDS to leave a message with any person who may answer my phone or on my voicemail of the following Number (please check all that apply):

- ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None-Please just ask for a call back
- ☐ Other (please Explain)

I would like to give permission for the following person (s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patients refused to sign

☐ Communication barriers

☐ Emergency situation

☐ Other- please list

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provide for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level, in which case, you would be responsible for the difference.

Workers compensation claims will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which may or may not cover the entire fee. Any amount not covered by the carrier will be your responsibility.

Minors must be accompanied by a parent or legal guardian. If the parents are separated or divorced the person accompanying the minor will be responsible for the copayment at the time of service.

Payments

Patient Portion or patient co-pay is due at the time service are rendered- unless prior financial arrangement have been made.

Payments Information

- All major credit cards are accepted (Visa, MaterCard, Discover)
- Various financing option with CareCredit and Citihealth

Balances left over 90 days will incur an 18% or $10 minimum monthly charge. We realize the temporary financial problems may effect timely payment of your account. If such problem do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short cancelled/ Missed Appointments

Please give 48 hours' notice if you are unable to keep reserved time. Unless and emergency occurs, we accept to run time for your appointment, and we appreciate the same courtesy from you.

Short canceled or missed appointments will be charge one dollar per minute of time allotted for your appointment.

By Signing below I acknowledge I have read and understand the guidelines above.

Signature _____ Date: _____

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Financial Agreement

Our payment methods are as following: (please indicate one)

1. Accept dental insurance- with current credit card on file for security purposes and difference not covered by your insurance
(when permitted as some plans do not allow payment directly to the office.)

Please check: ☐ Visa ☐ MasterCard

Card Number _____ Exp Date _____ 3 Digit code _____

I understand that I will personally responsible that all services are paid in full. I understand my credit card will billed automatically for any differences that are not received by insurance company.

Signature of cardholder X _____

Name of card holder _____

2. Bill my insurance on my behalf and I will pay for my appointments as I go.

3. No dental insurance – payment on day services

Consent for Collection, Use and Disclosure of Personal Information

I agree that Dr. Barrios has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I may be provided with a copy form at anytime and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy at this dental office and is in accordance with the Personal Health Information Protection. Act 2004

X _____ Date: _____