

GUELPH DENTIST

Dr. Urszula Barrios

www.guelphdentist.com

824 Gordon Street, Guelph, Ontario N1G 1Y7

519-767-6453

PATIENT INFORMATION

Date: _____

Patient: _____

Last

First

Preferred

Pronouns: _____

Marital status: _____

*If child, provide parent/guardian name: _____	*If student: ☐ full-time ☐ part-time
Name	School: _____ Student ID# _____

Patient date of birth: _____

HC#: _____

Address: _____

Home phone: _____

Cell phone: _____

City

Province

Postal Code

Other: _____

Email: _____

How did you hear about our office? _____

Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person

Name: _____ Relation: _____ Tel: _____

INSURANCE INFORMATION

Subscriber: _____
First Last Middle

Subscriber date of birth: _____

Subscriber employer: _____

Patient Relation to Subscriber _____

Primary insurance carrier: _____

Group/policy number: _____ ID#: _____

Secondary insurance carrier: _____

Group/policy number: _____ ID#: _____

MEDICAL HISTORY

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 your answers and can explain any that you do not understand. Please fill in the entire form.

Family Doctor: _____ Phone#: _____

Clinic/Facility: _____

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain. ☐ Yes ☐ no ☐ unsure

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? If yes, please explain.
☐ Yes ☐ no ☐ unsure

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them below:
☐ Yes ☐ no

Drug name	Dosage	Reason

5. Do you have any allergies? If yes, please list them below. ☐ Yes ☐ no

6. Have you ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.
☐ Yes ☐ no ☐ unsure

7. Do you have or have you ever had asthma? ☐ Yes ☐ no ☐ unsure

8. Do you or have you ever had any heart or blood pressure problems? ☐ Yes ☐ no ☐ unsure

9. Do you or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. Infective endocarditis), a heart condition from birth (i.e. Congenital heart disease) or a heart transplant?
☐ Yes ☐ no ☐ unsure

10. Do you have a prosthetic or artificial joint? ☐ Yes ☐ no ☐ unsure

11. Do you have any conditions or therapies that could affect your immune system (e.g. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? ☐ Yes ☐ no ☐ unsure

12. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ no ☐ unsure
13. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ no ☐ unsure
14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain
☐ Yes ☐ no ☐ unsure
-

15. Do you have or have you ever had any of the following? Please Check

- | | | | | |
|---|--|---|--|--|
| ☐ Chest pain, angina | ☐ Rheumatic fever | ☐ Pacemaker | ☐ Steroid therapy | ☐ Seizures (epilepsy) |
| ☐ Heart attack | ☐ Mitral valve prolapse | ☐ Lung disease | ☐ Diabetes | ☐ Kidney disease |
| ☐ Stroke, TIA | ☐ Tuberculosis | ☐ Stomach ulcers | ☐ Thyroid disease | ☐ Shortness of breath |
| ☐ Heart murmur | ☐ Cancer | ☐ Arthritis | ☐ drug/alcohol/cannabis use or dependency | ☐ Osteoporosis |

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
☐ Yes ☐ no ☐ unsure
-

17. Do you smoke or chew tobacco products? ☐ Yes ☐ no ☐ unsure
18. Are you nervous during dental treatment? ☐ Yes ☐ no ☐ unsure
19. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
☐ Yes ☐ no ☐ unsure
-
20. Do you identify as a patient with a disability? If yes, please explain ☐ yes ☐ no ☐ unsure
-
21. Are there any diseases or medical problems that run in your family? ☐ yes ☐ no ☐ unsure
-

DENTAL HISTORY

1. What is the reason for your visit today? Are you currently experiencing any dental problems?

2. Have you been seeing a dentist regularly? If not, why? ☐ Yes ☐ no ☐ unsure

3. Are you nervous during dental visits? ☐ Yes ☐ no ☐ unsure
4. Have you had a bad experience of complications during dental treatment? ☐ Yes ☐ no ☐ unsure

5. When was your last dental visit? What was done at that appointment?

6. When did you last have dental x-rays?

7. Have you ever seen a dental specialist? If yes, please explain. ☐ Yes ☐ no ☐ unsure

8. How often do you brush your teeth? Floss? Do your gums bleed while brushing or flossing?

9. Have you been told to take antibiotics before your dental appointment? ☐ Yes ☐ no ☐ unsure

10. Do you feel that you have bad breath? ☐ Yes ☐ no ☐ unsure

11. Are you happy with the appearance of your teeth? ☐ Yes ☐ no ☐ unsure

12. Do you have any problems with your jaw (clicking, pain, limited movement)? ☐ Yes ☐ no ☐ unsure

13. Have you ever had an injury to the teeth or jaws? ☐ Yes ☐ no ☐ unsure

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

15. Is there anything else you want us to be aware of regarding your dental care?

To the best of my knowledge, the above information is correct:

Patient/parent/ Guardian Signature:

Date:

Dentist Signature:

Date:

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I am aware of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the term in which my personal health and identification information is 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 the right to review a copy of these 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 to obtain a current copy of their privacy practices.

I agree that Dr. Barrios has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information

By Providing my signature below, I attest that I understand and agree to the above HIPAA Policy.

Signature:

Date:

FINANCIAL GUIDELINES**Insurance**

We accept all major dental insurance payments, however we may not be an "in network" provider for your plan. This means that we can submit your insurance claim but you will be responsible for payment at the time services are rendered and you will be reimbursed by your insurance carrier.

No estimate is a guarantee of payment. please understand, you are responsible for all charges not paid by your insurance.

Workers compensation, ODSP, CDCP claims will be filed for you. The carrier will assign a dollar amount that will be paid towards the claim, which 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. The person accompanying the child will be responsible for paying any differences at the time of service unless other arrangements were made prior to the appointment.

Payments

Patient portion or co-pay is due at the time services are rendered - unless prior financial agreements have been made.

we accept all major credit cards, If you wish to keep a credit card on file, you may enter the information here:

Card#: _____ Expiry: _____ CVV: _____

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 issues do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short notice cancellations/missed appointments

Please give 48 hours notice if you are unable to keep reserved time.

Repeated missed or short notice cancellations may be charged a penalty fee.

By signing below, I acknowledge I have read and understand the guidelines above:

Signature: _____

Date: _____

PATIENT INFORMATION RELEASE FORM

Dear Dr. _____

I authorize you to forward the dental x-rays for the following:

Patient(s) Name

To Dr. Urszula Barrios

I, the undersigned patient (or legal guardian) hereby authorize the release of my dental records to Dr. Urszula Barrios. I release you from all legal responsibility or liability that may arise from this authorization.

Signature (Parent/Guardian):

Date:

For dental office to complete:

Please indicate the last time the patient had the following procedures completed:

New patient exam/COE: _____

Recall: _____

FMS or PAN: _____

Bitewings: _____

Hygiene: _____

FMP: _____

Please forward all recent radiographs, probing and any other information you feel necessary to info@guelphdentist.com or fax: 519-767-6686.

Thank you kindly for your cooperation!