GUMTREE DENTAL CARE

ADULT NEW PATIENT FORM

Fields marked with * are mandatory

Patient Information

First Name*: _____ Last Name*: _____

Date of Birth (MM/DD/YYYY)*: _____ / _____ / _____ Gender*: ☐ Male ☐ Female ☐ Prefer not to say

Email*:_____

Home Phone*: _____ Cell Phone*: _____

Address*: _____

Occupation:_____Who referred you to our office? _____

Emergency Contact

Name*: _____

Relationship to Patient*: _____Phone*: _____

Physicians

Family Doctor*: _____ Phone*: _____

Specialist 1: _____ Specialty: _____ Phone: _____

Specialist 2: _____ Specialty: _____ Phone: _____

Medical Conditions

The dental staff will review your medical form and answer questions. Please complete the following:

Any treatment for a medical condition within the past year? ☐ Yes ☐ No ☐ Not sure/Maybe

If yes, please explain _____

Last medical checkup? _____

Any changes to your general health in the past year? ☐ Yes ☐ No ☐ Not sure/Maybe

If yes, please explain _____

5734 Hazeldean Rd, Unit 4, Stittsville, ON K2S 2R1
info@gumtreedentalcare.ca
343-459-3572

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List of medications, nonprescription drugs, or herbal supplements:

- Please include doses taken
- Please also advise if you are taking any medications for blood thinners, osteoporosis, steroids, diabetes, high blood pressure

_____

_____

_____

Any allergies to following medications?

☐ Penicillin or other antibiotics ☐ Sulfa drugs ☐ Aspirin/NSAIDS ☐ Iodine/Silver ☐ Codeine

Any allergies ie: hay fever, seasonal, foods?* _____

Any adverse reaction to medication or injections? ☐ Yes ☐ No ☐ Not sure/Maybe

If yes, please explain _____

Have you ever been hospitalized for any illness or conditions? ☐ Yes ☐ No

If yes, please explain _____

Please check mark any of the following that apply past or present*

☐ Heart Attack	☐ Easy Bruising	☐ Gall bladder	☐ AIDS
☐ Heart surgery	☐ Excessive Bleeding	☐ Jaundice	☐ HIV infection
☐ Angina (Chest Pain)	☐ Anemia	☐ Malaria	☐ Diabetes HbA1c
☐ High blood pressure	☐ Haemophilia	☐ Thyroid disease	☐ Kidney trouble
☐ Low blood pressure	☐ Von Willebrand	☐ Tuberculosis	☐ Liver ciarrhosis
☐ Fainting/dizziness	☐ Hives, skin rash	☐ Hiatus hernia	☐ Depression
☐ Infective Endocarditis	☐ Dermatitis	☐ Artificial joint/hip	☐ Psychiatric treatment
☐ Rheumatic fever	☐ Cancer treatment	☐ Arthritis	☐ Anxiety
☐ Prolapsed mitral valve	☐ Radiation Therapy	☐ Disability	☐ Seizures/Epilepsy
☐ Artificial heart valves	☐ Chemotherapy	☐ Asthma	☐ Hepatitis A/B/C/D/E
☐ Heart murmur	☐ Ulcers	☐ Persistent cough	☐ Glaucoma
☐ Congenital heart lesions	☐ Gastritis	☐ Emphysema	☐ Osteoporosis
☐ Cardiac pacemaker	☐ Acid reflux	☐ COPD	☐ None of the above
☐ Stroke	☐ Ulcerative colitis	☐ Sleep apnea	

Please elaborate further if you have any of the above conditions.

_____

_____

_____

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Social History

Do use tobacco or other tobaccolike substances? ☐ Yes ☐ No

If yes, frequency and how many years? _____

Previous Smoker? ☐ Yes ☐ No If yes, how many years smoke free?_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week?_____

Women only

Currently pregnant? ☐ Yes ☐ No ☐ Not sure/Maybe

Are you currently breast feeding? ☐ Yes ☐ No

Dental History

Previous Dental Clinic:_____ Phone: _____

Last time seen by dentist: _____

Last cleaning: _____ Last dental xrays: _____

Insurance

Do you have dental insurance?* ☐ Yes ☐ No

Insurance Company: _____

Policy #: _____ Certificate #: _____

Subscriber Relationship: _____ DOB (MM/DD/YYYY)*: ____ / ____ / _____

Secondary Insurance (if applicable): _____

Secondary Policy #: _____ Secondary Certificate #: _____

Subscriber Relationship: _____ DOB (MM/DD/YYYY)*: ____ / ____ / _____

Consent

The privacy of your personal information is a priority in our commitment to providing highquality dental care. We recognize the importance of safeguarding your personal data and are dedicated to handling it responsibly, ensuring its collection, use, and disclosure are managed with the utmost care. All staff members who have access to your personal information are thoroughly trained in its proper handling and protection. In this consent form, we have detailed the measures our office takes to ensure that:

- Only the necessary information is collected from you.
- Your information is shared exclusively with your consent.
- The storage, retention, and destruction of your personal information adhere to applicable legislation and privacy protocols.
- Our privacy practices are fully compliant with the privacy standards set forth by our regulatory body, the Royal College of Dental Surgeons of Ontario, as well as relevant laws.
- To provide safe and efficient patient care.

- To ensure continuous highquality service.
- To assess your health needs.
- To deliver appropriate healthcare services.
- To inform you of available treatment options.
- To facilitate communication, including scheduling and confirming appointments, followups, and billing matters.
- To offer and provide treatment and care related to the oral and maxillofacial complex and general dental care.
- To communicate with other healthcare providers, including specialists and referring or peripheral dentists.
- To submit dental claims for thirdparty adjudication and payment.
- To meet legal and regulatory obligations, including providing patient records to the Royal College of Dental Surgeons of Ontario as required by the Regulated Health Professions Act.
- To deliver patient charts and records to the dentist's insurance carrier for liability assessment and damage quantification, if applicable.
- To prepare documentation for the Health Professions Appeal and Review Board (HPARB).
- To allow potential purchasers, practice brokers, or advisors to assess the practice or conduct an audit in preparation for a practice sale.
- To invoice for goods and services.
- To process credit card payments.
- To collect outstanding accounts.
- To ensure compliance with regulatory requirements.
- To comply with applicable laws and regulations.

By signing this consent section of the Patient Consent Form, you acknowledge that you have provided informed consent for the collection, use, and/or disclosure of your personal information for the purposes outlined. Should a new purpose arise, we will seek your approval in advance.

Your information may be accessed by regulatory authorities by the Regulated Health Professions Act (RHPA) to enable the Royal College of Dental Surgeons of Ontario to fulfill its mandate under the RHPA, as well as for the defence of any legal matters.

Under no circumstances will our office provide your insurer with your confidential medical history. If such a request is made, we will promptly forward the information to you for review and obtain your explicit consent before any disclosure.

When we receive unusual requests for your information, we will contact you to obtain your permission before releasing any data. Additionally, we may inform you if we believe that such a release would be inappropriate. You have the right to withdraw your consent for the use or disclosure of your personal health information at any time.

PATIENT CONSENT: I have reviewed the information provided above, which outlines how your office will use my personal information and the measures being taken to protect it. I consent to Gumtree Dental Care collecting, using, and disclosing my personal information to the following individual(s).

I filled out this form to the best of my knowledge and confirm that the following information is correct.

Write your signature below.

Signature

Print Full Name _____

Date_____

I understand that Protected Health Information (PHI) or sensitive information should not be included in this message.

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