Dr. R. Navaneelan & Associates
Family & Cosmetic Dentistry

NEW PATIENT FORM

Your cooperation in completing this questionnaire is essential to provide you with safe and appropriate dental care.
All information is strictly confidential. PLEASE PRINT CLEARLY

Select One: Mr ☐ Mrs ☐ Mstr ☐ Miss ☐ Ms ☐ Dr ☐

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH (DD/MM/YY): _____ GENDER: _____

HOME ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

OCCUPATION: _____ EMPLOYER: _____

CURRENT COLLEGE/UNIVERSITY STUDENT: YES ☐ NO ☐ SCHOOL: _____

EMERGENCY CONTACT NAME: _____

RELATION: _____ CONTACT NUMBER: _____

HEALTH CARD #: _____ EXPIRY: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

HOW WOULD YOU LIKE TO RECEIVE APPOINTMENT CONFIRMATIONS? CHOOSE **ONE**

TEXT (CDN numbers only) ☐ EMAIL ☐ PHONE CALL: HOME ☐ CELL ☐

FAMILY PHYSICIAN: _____ PHONE: _____

PHARMACY: _____ LOCATION: _____

NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALTY: _____ PHONE OR ADDRESS: _____

NAME OF MEDICAL SPECIALIST: _____

AREA OF SPECIALTY: _____ PHONE OR ADDRESS: _____

PARENT/GUARDIAN/CAREGIVER 1 INFORMATION

NAME: _____ PHONE: _____

RELATION: _____

ADDRESS (N°, STREET, CITY, PROVINCE): _____

PARENT/GUARDIAN/CAREGIVER 2 INFORMATION

NAME: _____ PHONE: _____

RELATION: _____

ADDRESS (N°, STREET, CITY, PROVINCE): _____

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INSURANCE INFORMATION (IF THERE IS DENTAL COVERAGE, PLEASE COMPLETE THE FOLLOWING)

PRIMARY POLICY HOLDER: _____ D.O.B. (DD/MM/YY)_____

EMPLOYER: _____

RELATION: _____

INSURANCE CO: _____

POLICY PLAN#: _____ DIVISION: _____ SUBSCRIBER ID: _____

SECONDARY POLICY HOLDER: _____ D.O.B. (DD/MM/YY)_____

EMPLOYER: _____

RELATION: _____

INSURANCE CO: _____

POLICY PLAN#: _____ DIVISION: _____ SUBSCRIBER ID: _____

TERTIARY POLICY HOLDER: _____ D.O.B. (DD/MM/YY)_____

EMPLOYER: _____

RELATION: _____

INSURANCE CO: _____

POLICY PLAN#: _____ DIVISION: _____ SUBSCRIBER ID: _____

Our office is committed to helping patients get the most benefit from their dental insurance; however, insurance policies vary greatly. Therefore, due to the complexity of insurance contracts, you are fully responsible for knowing your own insurance plan and what treatment it does and does not cover. Treatment is recommended based on what you need; not based on insurance coverage. As a courtesy, we will gladly send your claim electronically for you, on your behalf, to your insurance company provided that your company allows electronic submission.

We wish to stress that the financial responsibility for services rendered rests with the patient and his/her family. Regardless of any dental coverage, your insurance policy is a contract between you and your insurance company. We cannot guarantee payment or coverage of your claim. If your insurance fails to pay the claim, you ultimately continue to be responsible to pay for all services rendered in full. Payments can be made by Debit, Visa or MasterCard.

I agree to pay all fees and charges for the services rendered at Dr. Rachel Navaneelan & Associates Family & Cosmetic Dentistry. I agree to pay all charges when presented with a statement unless prior financial arrangements are agreed upon in writing. I understand and agree, regardless of my insurance, that I am ultimately responsible for any unpaid balance on my account.

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

Print Name: _____ Date: _____

Signature: _____

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PATIENT DENTAL HISTORY

1. Reason for today's visit: _____
2. Have you been visiting the dentist regularly? ..... Yes□ No□
3. Last dental visit _____ Cleaning _____ X-rays _____
4. How often do you brush your teeth? _____ Floss your teeth? _____
5. Do your gums bleed regularly? ..... Yes□ No□
6. Are you teeth sensitive to…… Hot □ Cold □ Biting □ Sweets □ Sour □ N/A □
7. Do you feel any pain in your teeth? ..... Yes□ No□
8. Have you had any head, neck or jaw injuries/surgeries? ..... Yes□ No□
9. Do you have difficulty swallowing? ..... Yes□ No□
10. Does your jaw crack, click or pop when opened widely? ..... Yes□ No□
11. Do you grind or clench your teeth during the day or night? ..... Yes□ No□
12. Do you bite your lips/cheeks frequently? ..... Yes□ No□
13. Have you ever experienced any growths, lumps or sore spots in your mouth? ..... Yes□ No□
14. Have you noticed any loosening/movement of your teeth? ..... Yes□ No□
15. Have you ever had periodontal (gum) treatment? ..... Yes□ No□
16. Have you ever had orthodontic treatment (braces/clear aligners)? ..... Yes□ No□
17. Have you ever had problems with previous dental treatment? ..... Yes□ No□
18. Have you ever had treatment with a dental specialist? ..... Yes□ No□
19. Are you satisfied with the appearance of your teeth? ..... Yes□ No□
20. Are you nervous during dental treatment? ..... Yes□ No□
21. Do you wear any partials or dentures? ..... Yes□ No□
    If YES, please specify and indicate date of initial placement _____
    _____
22. Do you have any crowns, bridges or veneers? ..... Yes□ No□
    If YES, please specify and indicate date of initial placement _____
    _____
23. Please list any other information that you feel we should have to provide you with the best possible dental care: _____
    _____
    _____

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MEDICAL HISTORY QUESTIONNAIRE

1. Do you have any health problems?.....Yes□ No□
   If yes, please provide details: _____
   _____
2. Has there been any change in your general health or weight in the past year?.....Yes□ No□
   If yes, please explain: _____
3. Are you currently being treated for any medical conditions or have been treated in the last year? Yes□ No□
   If yes, please explain: _____
   _____
4. When was the last time you had a medical examination? _____
   Were any problems identified?.....Yes□ No□
   If yes, please explain: _____
5. Have you ever been hospitalized for any illness or operations?.....Yes□ No□
   If yes, please explain: _____
6. Are you taking any medications, non-prescription drugs or herbal supplements?.....Yes□ No□
   If yes, please list and provide reason for taking: _____
   _____
7. Have you ever been prescribed Bisphosphonates for Jaw Disease, Cancer, Menopause or Osteoporosis?
   .....Yes□ No□
   If yes, when? _____ Are you currently taking any? Yes□ No□
   □ Didronel (Etidronate) □ Aredia (Pamidronate) □ Fosomax (Alendronate) □ Actonel
   □ (Risedronate) □ Zometa (Zoledronate) □ Boniva (Ibandronate) □ Prolia (Denosumab)
8. Do you have any allergies?.....Yes□ No□
   If yes, please list using the categories below:
   Medications: _____
   Latex/Rubber Products: _____
   Other (hay fever, foods): _____
9. Have you had a peculiar or adverse reaction to any medicines, injections or dental local anaesthetic?
   .....Yes□ No□
   If yes, please explain: _____
10. Do you have or have you ever had a replacement or repair of a heart valve, pacemaker, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or heart transplant?.....Yes□ No□
    If yes, please explain: _____

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Medical History Questionnaire continued

11. Have you ever been advised by your doctor to take prophylactic antibiotics before your dental treatment due to heart conditions or joint replacement?.....Yes☐ No☐

    If yes, please explain: _____

12. Do you have a prosthetic or artificial joint?.....Yes☐ No☐

    If yes, please provide details: _____

13. Do you have any conditions or have undergone therapies that could affect your immune system (Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?.....Yes☐ No☐

    If yes, please explain: _____

14. Have you ever had hepatitis, jaundice, liver disease or gastrointestinal disorders?.....Yes☐ No☐

    If yes, please explain: _____

15. Do you have a bleeding problem, bleeding disorder, bruising tendency or have had a blood transfusion?.....Yes☐ No☐

    If yes, please explain: _____

16. Do you have or have you ever had any of the following (check all that apply) ..... Yes☐ No☐

☐ Fainting/Dizzy spells	☐ Tuberculosis	☐ Hyper/Hypoglycemia
☐ Eating disorder	☐ Fibromyalgia	☐ Mental or nervous disorder
☐ Rheumatic fever	☐ Stomach ulcers	☐ Circulatory problems
☐ Mitral valve prolapse	☐ High blood pressure	☐ Chest pain/Angina
☐ Heart murmur	☐ Low blood pressure	☐ Shortness of breath
☐ Asthma/Emphysema	☐ Seizures/Epilepsy	☐ Osteoporosis
☐ Lung disease	☐ Kidney disease	☐ Malignant Hyperthermia
☐ Liver disease	☐ Hyper/Hypothyroid	☐ Arthritis/Rheumatism
☐ Sleep Apnea	☐ HIV/AIDS	☐ Drug/Alcohol/Cannabis dependency
☐ Autism	☐ Hepatitis	☐ MRSA
☐ ADHD/ADD	☐ Steroid therapy	☐ High Cholesterol
☐ Acid Reflux/GERD		

☐ Leukemia-Year:_____ ☐ Heart Attack-Year:_____ ☐ Kidney Dialysis-Year:_____

☐ Diabetes-last sugar reading:_____ ☐ Stroke–Year:_____

☐ Cancer – Type: _____ Year:_____

☐ Chemotherapy – Last Treatment:_____ ☐ Radiation – Last Treatment: _____

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Medical History Questionnaire continued

17. Are there any conditions or diseases not listed above that you have or have had?..... Yes□ No□
    If yes, please explain: _____
    _____
18. Are there any diseases or medical problems that run in your family (cancer, diabetes, heart disease)? ..... Yes□ No□
    If yes, please explain: _____
19. Do you smoke?.....Yes□ No□ If yes, how much? _____
20. Do you vape?.....Yes□ No□ If yes, how much? _____
21. Do you chew tobacco?.....Yes□ No□ If yes, how much? _____
22. Do you use cannabis?.....Yes□ No□ If yes, how much? _____
23. Do you identify as a person with a disability?..... Yes□ No□
24. Have you experienced any new symptoms such a cough or illness since recent travel or otherwise? .....Yes□ No□
25. Have you had a recent exposure to a communicable infectious disease (i.e. measles, chicken pox or tuberculosis)? .....Yes□ No□
26. Have you experienced a new undiagnosed rash, lesion or break in your skin?..... Yes□ No□
27. Have you recently travelled to areas where endemic diseases are present? ..... Yes□ No□
28. Are your immunizations up to date? .....Yes□ No□
29. Is there any additional information related to your health that has not been addressed above? ..... Yes□No□
    If yes, please explain: _____
    _____
30. **FOR WOMEN ONLY:** Are you pregnant?.....Yes□ No□ Not sure/maybe□
    If yes, due date: _____
    Are you breastfeeding? ..... Yes□ No□

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APPOINTMENT POLICIES

Our office makes every effort to accommodate patients, including emergency patients. While we will do our best to meet your needs, it is not always possible to fit specific time requests into our full schedule.

Confirming Appointments: We do require confirmation for all appointments. It is important that you get back to us to confirm. If we are unable to reach you or we don't hear back from you, we reserve the right to cancel your appointment.

Cancellation Policy: Our schedule is often booked months in advance and we do require a minimum of 24 hours notice for cancellation. We understand that there may be circumstances that require you to change a scheduled appointment; however, in some cases when patients repeatedly cancel and/no show, we will not reschedule any future appointments. If you need to cancel or make changes to an already scheduled appointment, please call the main line at 613-933-7528.

I certify that I have read and understand the above information and the questions in this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

Signature (Patient/Parent/Guardian): _____

Date: _____

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PRIVACY, DISCLOSURE, & CONSENT

TO: Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry and Dr. Rachel Navaneelan Health Service

Information for our Patients

At Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry, all professional dental services are performed by licensed members of the ***Royal College of Dental Surgeons*** ("Dental Professionals"), and all institutional health care services are performed independently by Dr. Rachel Navaneelan Health Service, under the clinical supervision and control of Dental Professionals in a cost-sharing arrangement. Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry and Dr. Rachel Navaneelan Health Service are each independent entities providing independent services but for ease of administration may render joint invoices for their respective services. One or more of our Dental Professionals may have a financial interest in Dr. Rachel Navaneelan Health Service.

Privacy Act and Consent to Treatment

By signing this form, you acknowledge and agree that (i) you have read and understood the above information prior to any professional services being provided to you by any Dental Professional; (ii) you have been provided and have read a copy of the Privacy Code for Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry; and (iii) you agree to the collection, use and disclosure of your Personal Information in accordance with the Privacy Code. You can withdraw your consent at any time on the understanding that withdrawing your consent to certain information handling practices may impair the ability of Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry to provide the services you are requesting.

Acknowledgement regarding Information Provided

I, the undersigned, certify that I have provided an accurate and complete personal and medical – dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers regarding my medical – dental history. **Should there be any change in either my health status or any other information I have provided, I will advise this dental office**. As discussed with me, I authorize the Dental Professionals and all professional staff working under the supervision and control of the Dental Professionals to perform diagnostic procedures that may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary and I authorize the exchange of my personal information among Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry, Dr. Rachel Navaneelan Health Service, my medical doctor and another health care provider as reasonably necessary. I have been advised that this office maintains a Privacy Code and have been provided with a copy and that my personal information will be collected, used and disclosed within the guidelines of the Privacy Code. I also understand that my personal information will be retained by Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry and Dr. Rachel Navaneelan Health Service in accordance with their current practices, which may involve transfer and retention outside of Canada. I, the undersigned, acknowledge that the Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry and Dr. Rachel Navaneelan Health Service are relying upon the information which I have provided being accurate and complete.

_____
Patient name

_____ _____ _____
Print Name of ☐Patient ☐Parent ☐ Guardian Signature of ☐Patient ☐Parent ☐ Guardian Date

_____ _____
Reviewed by Dr. R. Navaneelan & Associates Family & Cosmetic Dentistry Date