Dr. Michael Handler
DENTISTRY

Welcome to Dr. Michael Handler Dentistry!

Prior to treatment, we require the following information. All information is strictly confidential. Please print.

Last Name: _____ First Name:_____

Birth Date: Day_____Month____Year_____ Gender: **M** **F**

Health Card Number: _____ E-Mail:_____

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

Address: _____ City_____ Postal Code:_____

Occupation: _____ Employer Name:_____

Phone:_____ Relationship to me: _____

Best Method(s) to confirm your appointment:

❑ Phone Number: _____ ❑ E-mail ❑ Text Message

Your Preferred appointment times:

Mon	Tues	Wed	Thu	Fri	Sat	Sun

How did you hear about us?

❑ Passed by/Saw the sign
❑ Flyer
❑ Magazine
❑ Internet
❑ Personal Referral: _____
❑ Other: _____

I am interested in the following treatments:

❑ Smile Assessment ❑ Orthodontics (braces) ❑ Dental Implants

❑ Other _____

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Medical History

Family Doctor Name:_____ Last Medical Checkup:_____

Have you ever been hospitalized or had a serious illness? **YES** **NO**

If yes, please explain:_____

Are you being treated for any medical condition at the present time, or have you been treated within the past year? **YES** **NO** If yes, which one:

Are you taking any medications, non-prescription drugs or herbal supplements of any kind?

YES **NO** If yes, please list:_____

(Women Only) Are you pregnant or breastfeeding?
YES **NO** If yes, how many months:_____

Are there any diseases or medical problems that run in your family? _____
E.g. Diabetes, cancer or heart disease.

Have you ever been told that you require pre-medication for dental treatment? **YES** **NO**

Indicate which of the following you have had, or have at present. Circle 'Yes' or 'No' to each condition.

Blood/ Immune System		
Anemia	YES	NO
Blood Transfusion	YES	NO
Bleeding Disorder	YES	NO
Excessive Bleeding	YES	NO
Long Healing	YES	NO
Radiation/Chemotherapy	YES	NO
AIDS/HIV	YES	NO
Cancer	YES	NO
Endocrine and Bone/Muscle		
Diabetes	YES	NO
Hypoglycemia	YES	NO
Thyroid Condition/Goiter	YES	NO
Arthritis/ Rheumatism	YES	NO
Artificial joints/Limbs	YES	NO
Osteoporosis	YES	NO
Neck Ache	YES	NO
Allergies		
Local Anesthetics	YES	NO
Latex Sensitivity	YES	NO
Penicillin	YES	NO
Aspirin or Codeine	YES	NO
Sulfa Drugs	YES	NO
Other (please list)	YES	NO

Respiratory/Heart		
Asthma/ Hay Fever	YES	NO
Sinus Problems	YES	NO
Difficulty breathing while laying down	YES	NO
COPD / Lung Disease	YES	NO
Rheumatic Fever	YES	NO
Heart Murmur	YES	NO
Chest Pain/Discomfort	YES	NO
Heart Attack /Stroke	YES	NO
High Blood Pressure	YES	NO
Pacemaker	YES	NO
Heart Surgery	YES	NO
Nervous System		
Convulsions/Epilepsy	YES	NO
Dizziness/Fainting	YES	NO
Psychiatric Treatment	YES	NO
Trigeminal Neuralgia	YES	NO
Digestive System		
Hepatitis	YES	NO
Liver disease/Jaundice	YES	NO
Ulcers	YES	NO
Kidney Trouble	YES	NO

Social:

How many alcoholic drinks do you have in a week? _____
Do you use tobacco in any form? YES NO If yes, how much? _____
Do you use any recreational drugs? YES NO If yes, how often? _____

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Dental History

1. When was your last dental visit? _____
2. How often do you use dental floss?____
3. How often do you brush your teeth?____
4. Have you ever had local anesthetic (freezing)?

   YES **NO** If yes, were there any complications? (Specify)_____

5. Does dental treatment make you nervous? (please circle)

   No **Slightly** **Moderately** **Extremely**

6. Is there anything we can do to make your visit more comfortable for you? _____

   _____

7. Describe in your own words your present dental condition: _____

   _____

Indicate which of the following you have had, or have at present. Circle 'Yes' or 'No' to each condition

Bleeding, soft gums	YES	NO
Unpleasant taste/bad breath	YES	NO
Blisters/lumps in mouth	YES	NO
Ortho treatment (Braces)	YES	NO
Clicking/popping jaw	YES	NO
Any accidents/blows to your jaw	YES	NO
Yellow teeth	YES	NO

Teeth sensitivity (hot & cold)	YES	NO
Facial pain	YES	NO
Difficulty chewing/swallowing	YES	NO
Does food pack or catch between your teeth?	YES	NO
Clenching or grinding	YES	NO
Shifting in teeth	YES	NO

8. If you were to change anything in your mouth, what would you change? _____

   _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be required, you have my permission to ask the respective health care provider who may release such information to you. I will notify the dentist of any change in my health or medication.

Signature:_____ Date: _____

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Informed Consent Form

For collection, use and disclosure of personal information:

Your privacy is important to us. Providing you with quality dental care means that we are committed to keeping your personal information safe and confidential.

We will collect, use and disclose information about you for the following purposes:

- to offer and provide treatment, care and services in relationship to your dental care
- to communicate with other treating health-care providers
- to allow us to maintain communication and contact with you
- to allow us to efficiently follow-up for treatment, care and billing
- to comply with legal and regulatory requirements in a timely fashion, according to the provisions of the Regulated Health Professions Act
- to deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages
- to process credit card payments and to collect unpaid accounts
- to assist this office to comply with all regulatory requirements and the law

Patient Consent

I have reviewed the above information that explains how the office will use my personal information, and the steps your office is taking to protect my information. I agree that Dr. Michael Handler Dentistry can collect, use and disclose personal information as set out above.

Signature: _____ Date: _____

For Imaging Records

During examinations, facial and intra-oral pictures will be taken. I consent to Dr. Michael Handler Dentistry using the pictures for the following:

To help my diagnosis, treatment plan and facilitate:

❑ Communication with me ❑ Communication with other dentists/laboratory ❑ Communication with my benefits ❑ For Education Purposes

To educate other patients on dental procedures:

❑ Show my face and teeth ❑ Show my teeth only

To be used as marketing material:

❑ Show my face and teeth ❑ Show my teeth only

To be used on our website:

❑ Show my face and teeth ❑ Show my teeth only

Image records Patient Consent

Name of Patient: Signature: Date: _____

_____

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Financial Policy

At Dr. Michael Handler Dentistry, our goal is to provide patients with the highest quality, informed dental care. Before we proceed with any treatment, all fees and financial arrangements will be discussed with you and you will have the opportunity to have all your questions answered first.

Payments and Dental Benefits
You will be asked to pay the fee at the time of service. You are responsible for the payment of all the fees for dental care rendered at Dr. Michael Handler Dentistry.

As a courtesy to all our patients, we will assist you in understanding your coverage and will send claims electronically, when possible, to ensure that you are reimbursed promptly. However, we strongly encourage you to be familiar with your personal plan(s), since benefit companies do not inform dentists of changes made to your plan(s). As well, benefit companies often refuse to provide us with information in this regard, in order to protect patient privacy. We understand this, as dental benefits are a contract between patients and employers, not the dentist. Please be aware of your benefits.

There is always the possibility that information provided over the phone can be inaccurate. Dr. Michael Handler Dentistry cannot be responsible for being aware of the entirety of coverage of your personal benefits. We can send a predetermination at your request and submit claims on your behalf. As well, we will help you with any request your benefit provider may have.

How would you like to pay for your visit? Please check one:

❑ Cash ❑ Debit ❑ Credit Card ❑ Other _____

Lateness/no show/cancellation policy
A scheduled appointment means that the dentist and the rest of the team have reserved a time specifically for you and no other patients are seen at that time. If you know you cannot make your appointment we require 2 business days notice so that we can give your scheduled time to another patient. Patients who do not follow this policy will be charged a fee and/or may no longer remain patients of this practice.

I have read and understand the financial policy of Dr. Michael Handler Dentistry:

_____ _____

Signature of Patient, Parent or Legal Guardian **Date**