Dentistry By Dr. Genoveva Caminschi

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Welcome

Please fill out this form completely.
The better we know you, the better we can meet your dental needs.

Personal Information

Name: Mr.☐ Mrs.☐ Ms.☐ Miss☐ Dr.☐

_____

Address:_____

City: _____ Postal Code: _____

Home #: _____ Cell #:_____

Work #: _____ E-mail: _____

Date of birth: _MM_ /_DD_ / _YYYY_ Age: _____

Height: _____ Weight: _____

Occupation: _____

Employer: _____

Whom may we thank for referring you?

_____

Reminder Info

How would you prefer we contact you?
(please check all that apply)

☐ Home # ☐ Cell # ☐ Work #

☐ E-mail ☐ Please don't call to remind me

Insurance information

Provider Name:_____

Group #: _____ ID #: _____

Insured's Name: _____

Relation to Insured: _____

Emergency Contact

Name: _____ Phone #: _____

Relationship: _____

Family Doctor: _____ Phone #: _____

EDI SIGNATURE

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.

_____ _____
Signature of patient, parent or guardian Date:

Patient I.D. # _____ D.R.M.S. Inc. © 1995 Rev:2

ASSIGN SIGNATURE

I hereby assign my benefits, payable from claims submitted electronically to Dr. _____ and authorize payment directly to him/her.

This authorization shall continue in effect until the undersigned revokes the same.

_____ _____
Signature of subscriber Date:

Patient I.D. # _____ D.R.M.S. Inc. © 1995 Rev:1

Dental History

When was your last Dental visit? _____

When did you last have dental x-rays? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

1. Have you been seeing a dentist regularly? ☐Yes ☐No
2. Do any of your teeth ache? ☐Yes ☐No
3. Have you ever been advised to take antibiotics before a dental appointment? ☐Yes ☐No
4. Do your gums bleed when you brush? ☐Yes ☐No
5. Do you have any pain when you chew? ☐Yes ☐No
6. Do you feel that you have bad breath? ☐Yes ☐No
7. Have you ever been in a vehicle accident or experienced any blows to your jaw? ☐Yes ☐No
8. Have you ever had any implant surgeries in one or both of your jaws or jaw joints? ☐Yes ☐No
   If "yes", who performed the surgery and when was it done?

_____

9. Are you being followed by a dental specialist? ☐Yes ☐No

10. Please list anything else not mentioned above regarding your past dental history:

_____

Medical History

The following information is required to enable us to provide you with the best possible dental care. Please be assured that all the information you provide is strictly private, and is protected by doctor-patient confidentiality. Dr. Caminschi and her staff will gladly help you better understand any questions you may find unclear.

1. Are you being treated for any medical condition presently or have you been treated within the past year?
   If yes, why? ☐Yes ☐No
   _____
2. When was your last medical check up?_____
3. Has there been any change in your general health in the past year? ☐Yes ☐No
   If yes, please explain
   _____
4. Are you taking any medications, non-prescription drugs or herbal supplements?
   If yes, please list ☐Yes ☐No
   _____
5. Do you have any allergies? ☐Yes ☐No
   If yes, please list using the categories below:
   a) Medications _____
   b) latex/rubber products _____
   c) other (i.e. hayfever, foods) _____
6. Have you ever had a peculiar or adverse reaction to any medications or injections?
   If yes, please explain ☐Yes ☐No
   _____

7. Do you have or have you ever had asthma? ☐ Yes ☐ No
8. Do you have or have you ever had any heart or blood pressure problems? ☐ Yes ☐ No
9. Do you have or have you ever had an artificial heart valve, an infection to the heart, a heart condition from birth, or a heart transplant? ☐ Yes ☐ No
10. Do you have a prosthetic or artificial joint? ☐ Yes ☐ No
11. Do you have any conditions or therapies that could affect your immune system (i.e. leukemia, AIDS, HIV, radiotherapy, chemotherapy)? ☐ Yes ☐ No
12. Have you ever had hepatitis, jaundice, or liver disease? ☐ Yes ☐ No
13. Do you have a bleeding problem, or bleeding disorder? ☐ Yes ☐ No
14. Have you ever been hospitalized for any illness or operation? ☐ Yes ☐ No
    If yes, please explain

    _____

15. Do you have or have you ever had any of the following:

Chest pain, angina	☐	Diabetes	☐
Heart attack	☐	Stomach Ulcers	☐
Stroke	☐	Arthritis	☐
Shortness of breath	☐	Seizures (epilepsy)	☐
Rheumatic fever	☐	Kidney disease	☐
Mitral valve prolapse	☐	Thyroid disease	☐
Heart murmur	☐	Drug/alcohol dependency	☐
Pacemaker	☐	Osteoporosis medication	☐
Lung disease	☐	Tuberculosis	☐
Cancer	☐	Steroid therapy	☐

16. Are there any conditions or medical problems that run in your family? ☐ Yes ☐ No
17. Do you smoke or chew tobacco products? ☐ Yes ☐ No
18. Are you nervouse during dental treatment? ☐ Yes ☐ No

FOR WOMEN ONLY: Are you breastfeeding or pregnant? ☐ Yes ☐ No
If pregnant, what is the expected due date?

_____

DISCLAIMER

I certify that I have provided an accurate and complete medical and dental history for myself (or my dependent) and have not omitted any information. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform Dr. Caminschi and/or her staff of any changes in my medical status. I authorize Dr. Caminschi and her team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient/Parent/Guardian Signature Date

Dentist Signature Date

Cancellation Policy

We require **at least 48 hours** advance notice for appointment cancellation or rescheduling. A **$50.00 & UP charge** will be added to your account given this policy is not respected.

Please also note that all cancellation fees must be fully paid prior to scheduling another appointment.

The treatment that is scheduled for you is specific to you. It is important to keep the scheduled dates and times such that Dr. Caminschi and her staff can properly complete your treatment. Three parties are at loss given a missed appointment- the patient who missed the allocated time; the patient who could have been scheduled during that time; and the doctor who was fully staffed and prepared for the appointment.

Patient/Parent/Guardian Signature **Date**

Financial Acknowledgement

Insurance

We provide services for our patients with the understanding that they are responsible for payment of any outstanding balances that may not be covered by their insurance. We will prepare and electronically/manually submit insurance claims to assist you in obtaining maximum reimbursement for your dental procedure, however please do keep in mind that Dr. Caminschi and her staff's treatment recommendations are based on your dental needs, and are not a reflection of your dental benefits.

Collections

In the event that the balance becomes more than 60 days overdue, and the patient has received 3 outstanding balance notices, billing may be turned over to an outside collection agency.

Patient/Parent/Guardian Signature **Date**

Consent for use of e-mail communication

To better serve our patients, this office has established an e-mail address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at: **info@drcaminschi.com**. Please remember however, that this form of communication is not appropriate for use in an emergency as there may be a delay in message delivery. **Should you require urgent or immediate attention please contact us by phone.**

When sending e-mail, please put the subject of your message in the subject line so that we can process it more efficiently. Also please put your name, and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails from our office by using the auto reply feature.

Please be advised that all communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, however, due to the nature of e-mail, third parties may have access to messages. When communicating from work, you should be aware that some companies consider e-mail corporate property and your message may be monitored. In addition, you should be aware that although your e-mail may be addressed specifically to Dr. Caminschi, her staff and/or colleagues may have access to this information.

☐ **I understand that this office will not be responsible for information loss or delay or breaches in confidentiality that are due to technical factors beyond this office's control.**

☐ **I understand and agree to the above e-mail policy.**

☐ **I agree to receive newsletters and other relevant office event information via e-mail.**

By signing below, you are agreeing that we may send medical relevant correspondence to you via e-mail, and that we may correspond with you via e-mail.

_____ _____

Patient Name **Patient Signature**

_____ _____

Date **E-mail**

Consent for Disclosure of Personal Information

Privacy of your personal information is an important part of our office. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information.

In this office, Dr. Genoveva Caminschi acts as the Privacy Information Officer. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us, and they are all trained in the appropriate uses and protection of your information.

Dr. Caminschi's dental office will ensure that:

- only necessary information is collected about you
- we only share your information with your consent
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols
- our privacy protocols comply with privacy legislation, standards of our regulatory body, and the Royal College of Dental Surgeons of Ontario (RCDSO), and the law.

By signing the consent section of this patient consent form, you agree to give your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. A copy of this consent form may be available to you if you wish to review it.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue.

When an unusual request is received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect by information.

I know that your office has a privacy code, and I can ask to see the code at any time

I agree that Dr. Genoveva Caminschi can collect, use and disclose personal information about _____ as set out above.

_____ _____

Patient Signature Print Name

_____ _____

Date Signature of Witness