

# Welcome to Roundhouse Dental

The following information is required by Dr. Matthias Hammer to assist in proper diagnosis and treatment. All information given is private and confidential. PLEASE PRINT

## Our Mission Statement

**TO DELIVER THE HIGHEST QUALITY OF DENTISTRY IN VANCOUVER  
AS PAIN FREE AS POSSIBLE.**

### OFFICE POLICY:

- We ask that all treatment be paid for at the time of service. For your convenience, we accept Visa, Master Card, Interact or cash. Patients with dental insurances will be reimbursed directly by their insurance company.
- We will discuss all treatment and fees with you prior to proceeding with any work.
- It is the patient's responsibility to know the limitations and coverage's of his/her Dental Insurance Policy.
- Our office can only give you an estimate of what your insurance company will pay.
- Insurance companies base their reimbursements on the BC Fee Guide, which is sometimes lower than of our fees. Therefore, you will not be reimbursed for the full amount paid to our office
- Dr. Hammer does his best to run on schedule and we ask that you do your best to be on time for scheduled appointments.
- We require 24 hours notice for cancellation or a fee may be charged.
- Our office has a privacy policy according to the personal information protection act. You may see the policy at any time.

I have read and understand the Office Policy.

Patient Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
D M Y

### What Brought You To Our Office?

- |   |  |
|---|--|
| <input type="checkbox"/> Referral from: _____ | <input type="checkbox"/> Website: <a href="http://www.roundhousedental.com">www.roundhousedental.com</a> |
| <input type="checkbox"/> Signage              | <input type="checkbox"/> Articles/Ads: _____   |
| <input type="checkbox"/> Location             | <input type="checkbox"/> Other: _____  |

**PATIENT REGISTRATION:** Today's Date: \_\_\_\_\_  
D / M / Y

Name: \_\_\_\_\_  
(last) (first) (middle)

Mailing Address: \_\_\_\_\_  
(Apt/Box#) (street #) (city/town)  
\_\_\_\_\_  
(prov/ state) (postal code/ zip) (country)

Phone #'s: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female  
D / M / Y

Emergency Contact: \_\_\_\_\_  
(Name) (Relation) (Phone #)

Physician/ Health Provider: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

**INSURANCE INFORMATION:**

**Primary Dental Insurance:** Patient's relation to insured:  Self  Spouse  Child  Other

Name of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
D / M / Y

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance: \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Certificate/ ID # \_\_\_\_\_

**Secondary Dental Insurance:** Patient's relation to insured:  Self  Spouse  Child  Other

Name of Insured: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
D / M / Y

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance: \_\_\_\_\_ Group/Policy # \_\_\_\_\_ Certificate/ ID # \_\_\_\_\_

**APPOINTMENT INFORMATION:**

**How would you like to be contacted for your appointments?**

Telephone  E-mail

**DENTAL HISTORY:** Today's Date \_\_\_\_\_  
D / M / Y

Is there a problem that you would like taken care of as soon as possible?

\_\_\_\_\_

Are you happy with the appearance of your teeth? If not, what would you like to see changed?

\_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

What are you looking for in a dental office? \_\_\_\_\_

On a scale of 1 – 10, how important is it for you to keep your natural teeth?  
(10 being very important) \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

How frequently do you see your dentist?  6 months  yearly  other  
Are your teeth sensitive to  cold  hot  sweets  other  
Do your gums bleed when  brushing  flossing  other  
Is your sugar intake  low  medium  high

Have you experienced any growth or sore spots in your mouth? \_\_\_\_\_

Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or do you have any questions or concerns?

\_\_\_\_\_

\_\_\_\_\_

### GENERAL INFORMATION

	<u>Please Circle</u>	
Do you wish your teeth could be brighter? .....	Yes	No
Do you like the shape of your teeth? .....	Yes	No
Do you experience chronic pain in your jaw, neck or shoulders? .....	Yes	No
Does your jaw crack or pop when opening wide? .....	Yes	No
Do you have difficulty opening and closing your mouth? .....	Yes	No
Do you have pain in your jaw joints, around your ears or side of face? .....	Yes	No
Do you ever experience frequent headaches or earaches? .....	Yes	No
Do you have difficulty chewing food? .....	Yes	No
Do you clench or grind your teeth while awake/asleep? .....	Yes	No
Do you breathe through your mouth while awake/asleep? .....	Yes	No
Do you bite your cheeks or lips regularly? .....	Yes	No
Do you feel or has anyone mentioned that you have bad breath? .....	Yes	No
Have you had periodontal treatment (treatment of the gums)? .....	Yes	No
Have you had orthodontic treatment (to straighten or realign teeth)? .....	Yes	No
Have you noticed any loose teeth, or shifting of teeth? .....	Yes	No
Have you had your bite adjusted or teeth ground? .....	Yes	No
Have you ever been advised to take antibiotics before a dental appointment? .....	Yes	No
Have you had oral surgery (removal of teeth/ implants/jaw joint)? .....	Yes	No

**HEALTH HISTORY:** Today's Date \_\_\_\_\_  
D / M / Y

**How much effort are you willing to make in order to maintain or optimize your overall health?**

- little effort                       some effort                       lots of effort

Are you presently under the care of a health provider? \_\_\_\_\_  
Name Phone

Specify: \_\_\_\_\_

Have you ever had a serious illness requiring hospitalization or extensive medical care?

Specify: \_\_\_\_\_

Are you presently or recently been taking any PRESCRIPTION or NONPRESCRIPTION drugs?

Specify \_\_\_\_\_

**Have you ever experienced any unusual reaction to any of the following? (Please check)**

- local anaesthesia (freezing)    aspirin    codeine    penicillin    iodine    sulfa  
 barbiturates (sleeping pills)    other medicines or chemicals \_\_\_\_\_

Have you ever been warned against taking any drug or medication? \_\_\_\_\_

**Do you have any of the following?**

- metal or latex allergies    asthma/hay fever                       hives/skin rashes                       food allergies \_\_\_\_\_  
 Other \_\_\_\_\_

**Do you or have you had any of the following? (Please check)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> heart murmur or any heart condition | <input type="checkbox"/> kidney disease     | <input type="checkbox"/> drug addiction             |
| <input type="checkbox"/> stomach/intestinal problems         | <input type="checkbox"/> diabetes           | <input type="checkbox"/> fainting                   |
| <input type="checkbox"/> joint replacement (hip, knee)       | <input type="checkbox"/> any lung disease   | <input type="checkbox"/> emphysema                  |
| <input type="checkbox"/> low or high blood pressure          | <input type="checkbox"/> hepatitis/jaundice | <input type="checkbox"/> AIDS or HIV                |
| <input type="checkbox"/> hyper/hypo glycaemia                | <input type="checkbox"/> liver disease      | <input type="checkbox"/> venereal disease           |
| <input type="checkbox"/> head/neck injuries                  | <input type="checkbox"/> stroke             | <input type="checkbox"/> tuberculosis               |
| <input type="checkbox"/> mental or nervous disorder          | <input type="checkbox"/> herpes             | <input type="checkbox"/> bronchitis                 |
| <input type="checkbox"/> arthritis or rheumatism             | <input type="checkbox"/> thyroid disease    | <input type="checkbox"/> scarlet or rheumatic fever |
| <input type="checkbox"/> epilepsy or seizures                | <input type="checkbox"/> sinus trouble      | <input type="checkbox"/> cancer: _____              |
| <input type="checkbox"/> other _____                         |   |   |

**PLEASE CIRCLE**

- |  |     |    |
|--|-----|----|
| Have you ever had any known contact with the AIDS Virus? .....             | YES | NO |
| Do you bruise easily or bleed abnormally? .....                            | YES | NO |
| Have you ever had any injury, surgery or x-ray therapy to your face? ..... | YES | NO |
| Do you have any physical limitations? .....                                | YES | NO |
| Do you wear contact lenses? .....  | YES | NO |
| Have you ever had cataract surgery? .....                                  | YES | NO |
| Do you have anxiety attacks? .....   | YES | NO |
| Do you have any disease, condition or problem that should be acknowledged? | YES | NO |
| If so, explain _____   |     |    |

**WOMEN ONLY:**

- |  |     |    |
|--|-----|----|
| Are you pregnant? If so, which month are you in? _____ | YES | NO |
| Are you taking any birth control pills? .....          | YES | NO |

# Roundhouse Dental

Dr. Matthias Hammer Inc.

## **PATIENT PRIVACY CONSENT FORM For Collection, Use & Disclosure of Personal Information**

In 2000, the federal government enacted the Personal Information Protection Act (PIPA) to set standards for how organizations collect, use, retain and disclose information about individuals. Initially, the legislation applied only to federally regulated industries, but as of January 1, 2004, it applies to all organizations.

Roundhouse Dental has always been, and will continue to be, committed to protecting your privacy, ensuring your personal information remains confidential. Collection of your personal information is an important part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using, retaining 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. It is important to us to provide this service to our patients.

All staff members who come in contact with your personal information have signed confidentiality agreements and are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to 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 protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

### **How Our Office Collects, Uses & Discloses Patient's Personal Information**

Our office understands the importance of protecting and respecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

This office will collect, use, retain and disclose information about you for the following purposes:

- to deliver safe and efficient patient care
- to assess your health needs and to advise, offer, provide treatment, care and services
- to identify and to ensure continuous high quality service
- to allow us to maintain communication and contact with you to book and confirm appointments and to distribute health care information (i.e. Hygiene reminder cards and educational dental newsletters)
- to communicate with our treating health care providers, including specialists and referring doctors
- to allow us to efficiently follow up for treatment, care and billing
- to invoice for goods and services, process credit card payments and to collect unpaid accounts
- to complete and submit insurance claims for payments, pre-authorizations and electronic submission
- for teaching and demonstrating purposes on an anonymous basis
- to comply with legal/regulatory requirements including the delivery of patient charts/records to governing bodies in a timely fashion when required, according to the provisions of the Regulated Health Professions Act
- to comply with agreements/undertaking entered into voluntarily by the member with governing bodies, including the delivery and/or review of patient's charts/records in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to evaluate the practice and to conduct an audit in preparation for a practice sale

- to deliver your charts/records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions Appeal and Review Board
- to assist our office to comply with the law and regulatory requirements

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed above. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

You may withdraw your consent for use or disclosure of your personal information at any time. It is also your right to choose not to provide us with some or all of your personal information, or deny us the use or disclosure of your information. If you exercise this right, please be aware that we may be limited in our ability or may not be able to provide you with dental services.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

Please do not hesitate to discuss our policies with any member of our staff team. Please contact us if you want a better understanding of our Privacy Policy, if you have any questions regarding our Privacy Policy or if you wish to address any concerns regarding our Privacy Policy.

**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 my information.

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

I agree that Roundhouse Dental can collect, use and disclose personal information about me as set out above in the information about the office's privacy policies.

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Patient / Guardian	Print Name	Signature	Date
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Witness	Print Name	Signature	Date
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