Patient Intake Form

Prefix (Mr./Mrs./Ms./Dr./Miss/Mstr.) ____________________
❑ Male ❑ Female
Birth Date: (mm/dd/yyyy) ____________________
Occupation: ____________________

Preferred Name: ____________________
First Name: ____________________
Middle Name: ____________________
Last Name: ____________________

Contact (Please fill out your preferred methods of contact)

❑ Home Phone: ____________________

❑ Cell Phone: ____________________

❑ Email: ____________________

❑ Work Phone: ____________________

We can communicate via phone, text or email. Please select all preferred contact methods.
❑ Phone ❑ Text ❑ Email

❑ Would you like to be contacted for short notice appointments?

Address

Street and number: ____________________

City: ____________________

Postal Code: ____________________

Emergency Contact
Name: ____________________
Phone: ____________________
Relationship: ____________________

Is there anything about the appearance of your teeth that you would like to change? ____________________
Have you ever whitened (bleached) your teeth? ____________________
Have you felt uncomfortable or self-conscious about the appearance of your teeth? ____________________
Have you been disappointed with the appearance of previous dental work? ____________________

How did you hear about us?

❑ Online Search
❑ Social Media
❑ Drove by/saw sign
❑ Word of mouth
❑ Radio Station: ____________________
❑ Community Event: ____________________
❑ Community Newspaper: ____________________
❑ Billboard/Signage
❑ Professional (doctor, dentist, denturist, etc.) ____________________

Whom may we thank for referring you?
____
What office are you leaving?
____
What is the biggest factor in your life that prompted this change?
____

Insurance (If applicable)

Primary:
Subscriber Name: ____________________
Subscriber Birth Date: (mm/dd/yyyy): ____________________
Insurance Company: ____________________
Policy Number: ____________________
ID Number: ____________________

Secondary:
Subscriber Name: ____________________
Subscriber Birth Date: (mm/dd/yyyy): ____________________
Insurance Company: ____________________
Policy Number: ____________________
ID Number: ____________________

Family Physician

Name: ____________________

Address: ____________________

Phone: ____________________

PATIENT CONSENT: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality dental care. **In this office, Dr. Dan Auprix 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.

Attached to this consent form, we have outlined what our office is doing to ensure that: only necessary information is collected about you; we only share our 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 the privacy legislation standards of our regulatory body, the Royal College of Dental Surgeons of Ontario and the law.

By singing 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. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. 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 defence of a legal issue.

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 consent for the collection, use and disclosure of my personal information as set out above in the information about the office's privacy policies.

____________________	____________________	____________________
Patient/Parent/Guardian Signature	Name of Patient/Parent/Guardian (print)	Date