REGISTRATION FORM

Section I: Patient Information Date_____

Title: Mr ☐ Ms ☐ Mrs ☐ Dr ☐ Male ☐ Female ☐

Name:_____ Preferred name: _____

Address:_____City:_____ Postal Code _____

Phone (_____)_____ Work Phone (_____) _____ext ____

Cell Phone (_____)_____ Email Address_____

Date of Birth:_____ (mm/dd/yyyy)

The best time to contact me is:_____ ☐ A.M. ☐ P.M.

On my ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email

Spouse or Parent's Name:_____ Employer_____ Work Phone_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____Phone_____

Section II: Responsible Party to Escort Patient Home after Sedation / Anaesthesia

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other: _____

Name:_____ Phone: (___)_____

Address:_____

City:_____ Postal Code :_____

Section III Insurance Information

Name of Insured / Subscriber_____ DOB_____ (mm/dd/yyyy)

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent

Insurance Company_____Group / Policy #_____

ID#_____ Employer: _____

---------- DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured / Subscriber_____DOB_____ (mm/dd/yyyy)

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent

Insurance Company_____Group / Policy #_____

ID#_____ Employer: _____

Section IV Health Care Team Information

Name of **Family Dentist** _____ City _____Date of last visit _____

Name of **Family Physician** _____City _____

Date of **last Medical Check up** _____(mm/dd/yyyy)

Richmond Hill Sleep Dentistry 406 – 250 Harding Blvd W, Richmond Hill, Ontario L4C 9M7
Tel: 1-800-917-0788 or 905-237-8412 **Fax:** 1-800-581-3635 **Email:** info@RHSleepDentistry.ca

PRE-ANAESTHESIA EVALUATION FORMS

Today's Date: _____

Patient Name _____ DOB _____ (mm/dd/yyyy)

1. Do you have Any **Allergy** to latex, medicine, food or environmental factors? Please list & provide detail _____	☐ Y ☐ N
2. Have you ever been **hospitalized** for any reason? Please specify date and procedure. Detail: _____ 3. Have you ever had **Surgery or General Anaesthesia or Sedation** in the past? If so, where & when? _____ Was there any problem with the sedation/anesthetic? _____ Has anyone in your family or relatives had a problem during an anaesthetic? Please explain: _____ ☐ Malignant Hyperthermia ☐ Difficult Airway ☐ Post-surgery stomach upset or vomiting ☐ Others/Detail: _____	☐ Y ☐ N
4. Are you taking any **current medication** / herbal supplement? Please list name and dose: _____ _____ _____ _____ _____	☐ Y ☐ N
5. Are you being treated for any illness presently? Detail: _____	☐ Y ☐ N
6. Do you have any **lung disease**? ☐ Asthma ☐ Frequent Coughing ☐ Croup ☐ COPD ☐ Others_____	☐ Y ☐ N
7. Do you have a **cold or flu** in the past 2 weeks?	☐ Y ☐ N
8. Do you **Smoke?** Or have exposure to 2nd hand smoke? Frequency: _____	☐ Y ☐ N
9. Have you been told you **snore at night** or suffers **Sleep Apnea** Detail: _____	☐ Y ☐ N
10. Do you have any **Heart disease**? ☐ Congenital heart disease ☐ Heart Murmur ☐ Abnormal heart rhythm ☐ High blood pressure ☐ History of Heart Attack ☐ Pulmonary Hypertension ☐ Chest pain/ Angina	☐ Y ☐ N
11. Do you suffer from **muscle** weakness, **joint** problem or neuromuscular disorder 12. Do you have any difficulty with **head, neck or jaw movement**? _____	☐ Y ☐ N
13. Have you been diagnosed with **Diabetes**? Date of diagnosis and type _____	☐ Y ☐ N
14. Do you have/ have you had CNS : ☐ Stroke ☐ Dementia ☐ Parkinson's disorder ☐ Seizure disorder ☐ Cerebral Palsy Rena: ☐ Kidney Disease or ☐ Renal Failure? _____ GI: ☐ Stomach Ulcer or ☐ Gastric Reflux? _____ Hepatic ☐ Liver Disease or ☐ Hepatitis(type?)_____ Endo: ☐ Thyroid disease or ☐ Endocrine disorder?_____ NMS: ☐ Arthritis or ☐ Rheumatic fever?_____ Immun: ☐ AIDS or ☐ Tuberculosis? _____ Hema: ☐ Bleeding Disorder or prolonged bleeding after minor trauma or dental extraction?_____ ☐ Down Syndrome? Please list if there is any associated complication ☐ Cancer or Malignancy? _____	☐ Y ☐ N

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15. Do you have ☐ Motion sickness ☐ Substance dependence ☐ Special need (autism, non-verbal, wheelchair etc) Please explain and specify: _____	☐ Y ☐ N
16. Are there any disease that runs in the **family**? Detail: _____	☐ Y ☐ N
17. FOR FEMALE: Are you **pregnant or Breast Feeding**? Detail: _____	☐ Y ☐ N
18. FOR CHILD: are you born Premature or have history of prolonged need of a breathing support? : do you have frequent nosebleed? Detail: _____	☐ Y ☐ N
19. Are there any other diagnosis or behavior issue we have not asked but we should know? Please advise: _____	☐ Y ☐ N
20. From a scale of 0 to 10, how would you rate your child or your **anxiety** toward dental treatment in general? Not anxious at all 0 1 2 3 4 5 6 7 8 9 10 Extreme anxiety	

BRIEF DENTAL HISTORY - QUESTIONNAIRE

1. What is your major concern?_____ If you have symptom, Location and trigger?_____ What helps to relieve the symptom? _____	☐ Y ☐ N
2. Please tell us a little bit about how the past Dental visits have gone When was your last dental visit? _____ What treatment was done? _____ What did you like? _____ What did you NOT like? _____ What would you like to know more? _____	
3. Oral Habit How often do you or your child consume sugary snacks between meals? _____ Tooth brushing frequency: ☐ none ☐ once a day ☐ twice a day ☐ >2/day Duration: ____ Flossing frequency: ☐ none ☐ once a day ☐ twice a day ☐ >2/day Duration: ____ **For child**: do you go to bed with a bottle at night? If so, content of bottle: _____	☐ Y ☐ N ☐ Y ☐ N

Patient/Guardian Signature : _____ *Patient/Guardian Print name*: _____

OFFICE USE ONLY

PHYSICAL EXAMINATION

Weight (kg)	BP	HR	RR	SpO2
ASA Class: I II III IV				

Airway MP TMD Neck H&N ROM	Chest/Cardiac	Venous Access	Other
Preop sedation:			

Consultant sign: _____ *Consultant print name*: _____

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CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Richmond Hill Sleep Dentistry understands the importance of protecting your personal information and our clinic is committed to protecting your individual privacy.

We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary to provide treatment and service to our patients:

1) To enable us to contact and maintain communication with you to distribute health-care information and to book and confirm appointments
2) To assess your health needs and providing safe and efficient treatment, care and services in relationship to dental care
3) To communicate with other health-care providers, including other dentists, physicians, pharmacists and specialist
4) To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the RCDSO in a timely fashion, when required, according to the provisions of the *Regulated Health Professionals Act* (RHPA)
5) To comply with agreements/ undertakings entered into voluntarily by the member with the RCDSO, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
6) To deliver records and charts information to the dentist's insurance carrier to enable insurance company to assess liability and quantify damages or coverage, as necessary
7) To invoice for goods and services
8) To process credit card payments
9) To collect unpaid account
10) To assist this office to comply with all regulatory requirements

We collect information that you voluntarily give us and you may withdraw your consent, and we will explain the ramifications of that decision and the process. Personal health information is securely retained in accordance with RCDSO's (Royal College of Dental Surgeons of Ontario) guideline. Should you have any question, please contact our clinic's privacy officer, Dr. Elise Wong.

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

Thank you for your support and understanding in helping our office to comply with all regulatory requirements, and generally with the law.

PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

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 Code, and I can ask to see the code at any time. I agree that Dr. Elise Wong can collect, use and disclose personal information as set out above in the information about the offices privacy policies.

_____ _____

Patient/Guardian Signature Signature of witness

_____ _____

Patient/Guardian Print name Date mm/dd/yyyy

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FINANCIAL AND APPOINTMENT POLICY

We are delighted to be a partner to improve your oral health.

Each person's care need is different and your treatment proposal will be based on a thorough assessment and examination during the initial exam/consult appointment.
Please note that due to the nature of certain conditions, a complete examination with x-ray and treatment plan is sometimes impossible until patient is under general anaesthesia or sedation. As such, an accurate estimate pre-treatment is impossible.

You are responsible to pay for treatment in full to our clinic on the day services are provided. For your convenience, we accept cash, VISA, Master Card, and Debit Cards. A receipt will be issued to you once payment is made.

Our clinic does not accept direct payment from insurance company. As a courtesy, we will assist you with dental insurance pre-determinations to help calculate your eligible coverage prior to treatment; or submit a claim electronically or provide you with a dental insurance claim form that you can submit to your private insurer or employer so that you may receive your eligible reimbursement. We cannot be responsible for the accuracy of our estimates because of the necessary change in course of treatment intra-operatively, and/or the changes in coverage that are continually occurring.

After initial exam, if deep sedation or general anaesthesia is indicated/desired, please note:

> Sedation or general anaesthesia time are specifically reserved for each patient, a $300.00 deposit is required to schedule the appointment. This amount will be credited toward treatment fee at the end. If it is necessary to change the appointment, ***2 business days***' notice is required to accommodate your request. **Failure to comply with this policy, or our pre-operative instruction resulting in loss of appointment, will result in your deposit being forfeited.**

Every effort will be made by our team to accommodate patients appointment requests, including caring for those patients that are in pain. Your understanding and cooperation is appreciated when on occasion, our team must keep you waiting in order to care for someone else in need.

I have read and agree to follow the policies, and understand all of the above instructions regarding my dental/ anaesthesia appointment.

_____ _____

Patient/Guardian Signature Date mm/dd/yyyy

_____

Patient/Guardian Print Name

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