THE BAY FAMILY DENTAL
Dr. Chynna Rae McLean DDS

40 COLLINGWOOD ST EAST
MEAFORD ON
N4L 1N5
519 538 1384
drmcleandds@gmail.com

# Welcome To Our Office

**Patient Name:**_____**Birthdate:**_____

**Address:**_____**City:**_____**PostalCode:**_____

**Home (____)**_____**Work (_____)**_____**Cell (_____)**_____

**Email Address**_____**How did you hear about us?**_____

**Emergency Contact**_____ **Phone**_____ **Relationship**_____

| **Primary Insurance** | **Secondary Insurance** |
|---|---|
| **Subscriber:** | **Subscriber:** |
| **Birthdate: day month year** | **Birthdate: day month year** |
| **Employer:** | **Employer:** |
| **Insurance Company:** | **Insurance Company:** |
| **Policy/Plan/Group #:** | **Policy/Plan/Group #:** |
| **I.d./Certificate #:** | **I.d./Certificate #:** |

## OFFICE POLICY FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION (PIPEDA, PHIPA)

Privacy of your personal information is an important part of providing you with quality dental care. We understand the importance of protecting your information. We are committed to collecting, using and disclosing your information responsibly. We try to be as open as possible with you about the way we handle your information.

***In this office, Dr. Chynna Rae McLean acts as the Privacy Information Officer.***

All staff members are aware of the sensitive nature of the information that you have disclosed. They are all trained in the appropriate uses and protection of your information.

An outline is available for you to read as to what our office is doing to ensure that:

- Only necessary information is collected;
- We share your information only with your consent;
- Storage, retention and destruction of your information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

I have reviewed the provided 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. Chynna Rae McLean, D.D.S., (Dentistry Professional Corporation)** can collect, use and disclose personal information about (name)_____as set out in the provided information about the office's privacy policies.

_____ _____ _____

**Signature** **date** **Witness initials**

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## ***Medical History Questionnaire.***

Are you currently being treated for any medical condition or have been treated within the past year? If yes, please explain: (circle) Yes No Not Sure/Maybe

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When was your last medical checkup_____

Has there been any change in your general health in the past year?
If yes, please explain: (circle) Yes No Not Sure/Maybe

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Are you taking any medications, non-prescription drugs or herbal supplements of any kind?
If yes, please explain: (circle) Yes No Not Sure/Maybe

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Do you have any allergies? If yes, please list them using the categories below:

a) Medications_____
b) Latex/rubber products_____
c) Other (i.e. Hay fever, seasonal/environmental, foods)_____

Have you ever had a **peculiar** or **adverse reaction** to any **medicines or injections (including dental freezing)**?
If yes, please explain: (circle) Yes No Not Sure/Maybe

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Do you have or have you ever had asthma? (circle) Yes No Not Sure/Maybe

Do you have or have you ever had any heart or blood pressure problems? (circle) Yes No Maybe

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? (circle) Yes No Not Sure/Maybe

Do you have a prosthetic or artificial joint? (circle) Yes No Maybe/Not Sure
Date of Surgery _____

Do you have any conditions or therapies that could affect your immune system (i.e. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? (circle) Yes No Not Sure/Maybe

Have you ever had hepatitis, jaundice or liver disease? (circle) Yes No Not Sure/Maybe

Do you have a bleeding problem or bleeding disorder? (circle) Yes No Not Sure/Maybe
Do you take blood thinners? Yes No Name:_____

Have you ever been hospitalized for any illnesses or operations? (circle) Yes No
If yes, please provide details:

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Do you have or have you ever had any of the following? Please check:

| | | | |
|---|---|---|---|
| ___Chest pain, angina | ___Rheumatic fever | ___Thyroid disease | ___Steroid therapy |
| ___Heart attack | ___Lung disease | ___pacemaker | ___Osteoporosis medications (ie. ACTONEL, FOSAMAX) |
| ___Stroke, TIA | ___tuberculosis | ___diabetes | |
| ___Mitral valve prolapse | ___Shortness of breath | ___Stomach ulcers | ___Drug use/ dependency |
| ___Kidney disease | ___Seizure/epilepsy | ___arthritis | ___Alcohol use/ dependenc |
| ___Cancer | Details of above: | | |

Are there any diseases or medical problems that run in your family (i.e. diabetes, cancer or heart disease)
Details:_____ (circle) Yes No Not Sure/Maybe

Do you smoke or chew tobacco products? (circle) Yes No Not Sure/Maybe

Are you nervous during dental treatment? (circle) Yes No Not Sure/Maybe

Would you be interested in Nitrous Oxide to make your visits more relaxing? Yes No Not Sure/Maybe

Are you breastfeeding or pregnant? Yes No Not Sure/Maybe Expected delivery date_____

Physician's
Name:_____Phone#_____

If necessary, I hereby give permission for release of my dental information to my doctor and/or your request of information from my doctor regarding my health during a dental procedure.

| Date | Drug Name | **Reason for Medication** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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**To the best of my knowledge, the above information is correct:**

_____ _____
**Patient/Parent/Guardian Signature** **Date**

_____ _____
**Dr. Chynna Rae McLean, DDS** **Date**

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**OFFICE USE:**

**Blood Pressure:**_____/_____. **Heart Rate:**_____

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# Financial Policy (Insured and Non-Insured)

The office of **Dr. Chynna Rae McLean, D.D.S., (Dentistry Professional Corporation)** is asking all patients to be responsible for their insurance coverage. Please keep our office informed of any changes in your plan.

Please note, due to the **"Privacy Act",** insurance companies are reluctant to provide dental offices with your benefit details. Therefore, we would like to avoid the disappointment of you proceeding with necessary treatment only to find that procedures are not covered. This office can estimate dental fees prior to treatment to your insurance provider if requested. We will be happy to assist in processing and submitting insurance claims electronically, or assisting you in this process. However, it is you, the policy holder who is responsible to provide payment in full to the office of Dr. Chynna Rae McLean regardless of insurance liability.

I have reviewed the above information explaining the privacy of my insurance coverage. I agree that it is my responsibility to make payment of all fees that are not covered by my existing insurance plans.

We accept many forms of payment, including Visa, Mastercard, Debit, Cash

Unless otherwise discussed payment is due in full at the time of treatment. Financing options are available, please discuss with a team member at any time prior to booking and confirming treatment.

_____ _____ _____
**Signature** **Date** **Witness initials**

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# DENTAL HISTORY QUESTIONNAIRE

**NAME:_____. DATE:_____**

1. Is there a dental problem that you would like treated immediately?
   _____

2. Date of your last dental visit _____
   Reason _____

3. Date of last dental scaling? _____

4. Last Dental x-rays taken? _____

5. How often do you brush your teeth? _____

6. Do you use mouth rinse? YES NO What brand? _____

7. How often do you floss? _____

8. Do you use a manual or power toothbrush?_____

9. Do you use any other dental aids (proxabrush,stimudents,etc.)? YES NO
   Name of dental aid/how often: _____

10. Do you smoke? YES NO
    How many per day? _____ How many years? _____

11. Are you interested in quitting? YES NO

12. Have you ever had any of the following treatments?

| | | |
|---|---|---|
| Periodontal treatment (treatment to your gums) | YES | NO |
| Orthodontics (braces) | YES | NO |
| Oral surgery (wisdom teeth extractions, etc.) | YES | NO |
| Root canal treatments | YES | NO |

13. Are any of your teeth sensitive to: HOT COLD SWEETS BITING
If yes: Which teeth and how long have they been sensitive?
_____

| | | |
|---|---|---|
| 14. Do you clench or grind your teeth while sleeping or awake? | YES | NO |
| If yes: Do you currently wear a bite guard? or have you in the past? | YES | NO |

| | | |
|---|---|---|
| 15. Do you have any growths or sores in your mouth? | YES | NO |

If yes: Where and how long has it been present? _____

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16. Do you get cold sores and/or canker sores? YES NO
If yes: How often _____

17. Do you experience pain in your jaw joints? YES NO

18. Do you get headaches? YES NO If yes, how often? _____

19. Do you wear dentures? If yes: Are you happy with the way they fit? YES NO

21. Are you happy with your smile?_____

22. Would you like to improve your smile?_____

23. Is there anything else you would like us to know?_____

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## Appointment Policy

**We will make every effort to schedule appointments to best fit your schedule. Your appointment time is reserved just for you!**
**If you cannot make your scheduled time, we ask you give us 48 hours or 2 business days notice to cancel or reschedule.**

**Last minute cancellations or no shows may be subject to a fee.**

**Signed:_____. Date:_____**