Serghei Ischenco, DD • Annie Feng, DD • Brendan Morrison, DD
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• Ste. 104 –2130 Lawrence Avenue East, Scarborough, ON M1R 3A6 • Tel: 416.438.5440
www.appledentures.ca

PERSONAL INFORMATION

Name:_____

Address:_____ Postal Code: _____

Phone No:_____Cell Phone:_____

E-Mail: _____Date of Birth:_____Male ❑ Female ❑

Dentist: _____Denturist: _____Date of Last Visit:_____

Insurance Co: _____Employer: _____

Policy No: _____Group No: _____

Name of Policy Holder: _____Date of Birth of Policy Holder: _____

2nd Insurance Info: _____

How did you hear about our clinic? Newspaper ❑ Internet Search ❑ Exterior Signage ❑ Mobile Signs ❑ Referral ❑

If referral, who should we thank? Name: _____

PLEASE READ: All professional services are charged **directly to the patient** and patients are personally responsible for payment of bills on their accounts when treatment is completed. We will prepare any necessary forms or reports to help you collect your benefits from insurance companies.

Date: _____ Signature:_____

MEDICAL / DENTAL HISTORY

Are you currently being treated by a physician? Yes ❑ No ❑ Has there been any change in your general health? Yes ❑ No ❑

Do you have any allergies? _____ Are you on any medication(s)? _____

Do you have any of the following? (check any that apply)

❑ Aids	❑ Heart Trouble	❑ Jaundice	❑ Arthritis	❑ Latex Allergy
❑ High Blood Pressure	❑ Anaemia	❑ Stroke	❑ Epilepsy	❑ Snoring
❑ Asthma	❑ Headaches	❑ Diabetes	❑ Tuberculosis	❑ Rheumatic Fever
❑ Hay Fever	❑ Hepatitis	❑ Sinus Trouble	❑ Kidney Trouble	❑ Excessive Bleeding
❑ Cancer	❑ Venereal Disease			

Have you had any other serious illnesses? _____

Is there anything else the Denturist should know about your health? _____

Are you presently wearing dentures? _____Age of dentures: _____

Do you have any lumps or sores in your mouth now? _____

Do you have burning sensation on your lips or tongue? _____ Dry mouth? _____

Does your jaw click when you chew? Yes ❑ No ❑ Condition of present Dentures:_____

Date of last reline – Upper: _____Lower: _____

Are you satisfied with your current dentures? Yes ❑ No ❑ What is the problem? _____

Do you think new dentures can help you? Yes ❑ No ❑ What foods are you having difficulty chewing? _____

I authorize release to my benefits plan administrator information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named denturist. This authorization shall continue in effect until the undersigned revokes the same.

Signature of patient, parent or guardian: _____Date: _____

CONSENT FORM

PERMISSION TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

Our office understands the importance of your personal information. We will collect and use your personal information for these appropriate purposes:

- To diagnose and provide safe and efficient health care
- To assess your oral health and advise you of your treatment options
- To communicate with you and your other health care providers
- For scheduling appointments, billing purposes, including dental insurance forms
- For teaching and demonstration, on an anonymous basis
- To comply with the College of Denturists, Provincial and Federal regulations and to generally comply with the law
- To comply with the audits and evaluations of the dental practice
- To provide invoices, process credit payments and collect unpaid accounts
- To permit potential purchases or their agents to evaluate and audit the practice in preparation for a potential sale of the practice

By signing this Consent Form you agree that you have provided your personal information. You consent to the collection, use and disclosure of the information for the appropriate purposes listed above. Your information may be accessed by the College of Denturists or other regulatory authorities acting under statute of a legal issue. We will seek your approval, in advance, if a new purpose should arise for the use and/or disclosure.

You may withdraw your consent for the use and disclosure of your personal information at any time. We will explain the process and the ramifications of your decision to do so.

I have reviewed the above information that explains how Apple Denture & Implant Solutions will use my personal information. I understand that Apple Denture & Implant Solutions safeguards my personal information and that I have access to it at any time. I know that Apple Denture & Implant Solutions has a privacy code in place and I can review it at any time.

I agree that Apple Denture & Implant Solutions may collect, use and disclose personal information about:

_____ as set out in the office's privacy policy.

Signature: _____ Please Print Name:_____

Date: _____ Witness:_____