ORAL AND MAXILLOFACIAL SURGEONS
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PLEASE PRINT CLEARLY

NAME: _____ _____
FIRST LAST

ADDRESS: _____APT.#_____ UNIT#_____

CITY: _____ POSTAL CODE: _____

HOME PHONE: ( )_____ BUSINESS: ( )_____ext._____

MOBILE: ( )_____ E-MAIL ADDRESS:_____

DATE OF BIRTH: _____ SEX: FEMALE_____ MALE _____
Day Month Year

HEALTH CARD#:_____ VERSION CODE:_____

NEXT OF KIN/CLOSEST RELATIVE:_____

RELATIONSHIP:_____HOME TEL #_____

WORK TEL # _____MOBILE TEL # _____

REFERRAL INFORMATION

REFERRED BY: (CIRCLE ONE) DENTIST/ DOCTOR/ SPECIALIST/ OTHER

NAME: _____ PHONE:_____

REGULAR DENTIST: _____ PHONE:_____

FAMILY DOCTOR:_____ PHONE:_____

INSURANCE INFORMATION

DENTAL INSURANCE: YES_____ NO_____ DUAL_____

PLEASE TURN OVER FOR FINANCIAL POLICY

FINANCIAL POLICY

**********PLEASE READ CAREFULLY AND SIGN**********

Our fees are in accordance with the current Ontario Dental Association's Oral and Maxillofacial Surgeons suggested fee guide. If you have dental insurance we will gladly submit, electronically, a pre-determination (estimate) for you. We will submit all claims electronically for you. The insurance company will pay you directly; we do not accept direct payment from the insurance company. All fees will be due at the time of treatment. We will accept Visa, MasterCard, Interac, and Cash. We do not except personal cheques.

FINANCIAL AGREEMENT for INSURED PATIENTS

I understand that an insurance claim form will be submitted electronically by the office. I am aware I will receive one of two forms, either a "claim acknowledgement form" or an "explanation of benefits" form. I have been informed that the predetermination is just an estimate and that the final fee will be determined at the time of surgery based on the difficulty of surgery. I understand that it is my responsibility to cover the costs of all treatment rendered by the oral surgeon, and that I am financially responsible for the full amount of the account. I understand that any concerns regarding the fees that the insurance company may or may not cover must be discussed with the surgeon prior to the surgery date.

PATIENT NAME _____

RELATIONSHIP TO POLICY HOLDER: CHILD _____ SPOUSE _____

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT_____

DATE_____

FINANCIAL AGREEMENT for NON-INSURED PATIENTS

I will be given a written estimate and am aware that it is just an estimate. I understand that it is my responsibility to cover the costs of all treatment rendered by the oral surgeon, and that I am financially responsible for the full amount of the account.

PATIENT NAME _____

PERSON RESPONSIBLE FOR THE ACCOUNT_____

RELATIONSHIP TO THE PATIENT_____

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT_____

DATE_____

CDAnet and You

Electronic Claims Submission is now a reality in our office. This new service has been developed jointly by some insurance carriers and your oral surgeon to offer better service to you.

Electronic Claims Submission saves you the effort and cost of mailing the insurance form yourself- your oral surgeon is providing this service for you. As well, your claims processor will be able to process your claim faster, which means that payments will be received in a more timely fashion than before.

CDAnet PATIENT INFORMATION FORM

Primary Insurance Information

Name of patient _____

Name of policy holder _____
Policy holder's date of birth _____
Day Month Year

Insurance company _____
Policy/ Group#_____
Subscriber ID / Certificate #_____
Place of employment _____
Relationship of patient to policy holder: Dependent _____Spouse _____
Are you claiming from more than one insurance company? No _____ Yes _____
If yes, complete the following section.

Secondary Insurance Information

Name of policy holder _____
Policy holder's date of birth_____
Day Month Year

Insurance company _____
Policy/ Group # _____
Subscriber ID / Certificate #_____
Place of employment _____
Relationship of patient to policy holder: Dependent _____Spouse _____

*******************Please inform us if you have triple coverage**************************

AUTHORIZED CONSENT TO RELEASE INFORMATION

"I authorize release, to my dental benefits plan administrator, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of service described to the named oral surgeon."

_____ _____
Signature of patient, parent or guardian Date

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

- 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 on the back of this consent. 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 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.
- You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

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 Code, and I can ask to see the Code at any time.

I agree that Spectrum Oral Surgery can collect, use

and disclose personal information about _____
(patient's name)

as set out above in the information about the office's privacy policies.

_____ _____
Patient/Guardian Signature Print name

_____ _____
Date Signature of Witness

PATIENT CONSENT FORM: 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. We understand the importance of protecting your personal information. We are committed to collecting, using 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.
- In this office, Dr. Andy Wong 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. They are all trained in the appropriate uses and protection of your information.

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 your 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 privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.*

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality dental care.

How Our Office Collects, Uses and Discloses Patients' Personal Information

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

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

- *to deliver safe and efficient patient care*
- *to identify and to ensure continuous high quality service*
- *to assess your health needs*
- *to provide health care*
- *to advise you of treatment options*
- *to enable us to contact you*
- *to establish and maintain communication with you*
- *to offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally*
- *to communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists*
- *to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments*
- *to allow us to efficiently follow-up for treatment, care and billing*
- *for teaching and demonstrating purposes on an anonymous basis*
- *to complete and submit dental claims for third party adjudication and payment*
- *to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act*
- *to comply with agreements/undertakings entered into voluntarily by the member with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes*
- *to permit potential purchasers, practice brokers or advisors to evaluate the dental practice*
- *to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale*
- *to deliver your charts and records to the dentist'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 (HPARB)*
- *to invoice for goods and services*
- *to process credit card payments*
- *to collect unpaid accounts*
- *to assist this office to comply with all regulatory requirements*
- *to comply generally with the law*