A Tradition of Excellence and Commitment to Quality

DR ARUN NARANG DENTISTRY PROFESSIONAL CORPORATION

WELCOME

Continued on back

TELL US ABOUT YOUR CHILD

Today's Date:_____ Child's Home Phone #:_____ SIN:_____

Child's name: _____ Child's D.O.B: _____ Age: _____

Nickname: _____ ☐ Male ☐ Female School: _____ Grade: _____

Child's Home Address: _____
Street City Province Postal code

When & Where are best times to reach you? _____ #: _____

Whom may we thank for referring you to our practice? (Please circle)

Another Patient/Friend Another Patient/Relative Doctor's Office Yellow Pages Newspaper Flyer
Welcome Wagon Website/Google Billboard/Outdoor signs Other: _____

PARENT'S INFORMATION

Parent's Marital Status: _____

Mother: NAME: _____ D.O.B: _____

EMAIL: _____ Phone: CELL _____ Work: _____

Address: _____ S.I.N: _____
Street City Province Postal code

Employer: _____ Length of Employment:____ D.L. #: _____

Father: NAME: _____ D.O.B: _____

EMAIL: _____ Phone: CELL _____ Work: _____

Address: _____ S.I.N: _____
Street City Province Postal code

Employer: _____ Length of Employment:____ D.L. #: _____

DENTAL INUSRANCE INFORMATION:

PRIMARY INSURANCE INFORMATION:

Insured's Name:_____ Insured's Employer: _____

Insurance Company:_____ Policy #: _____

Certificate or I.D. #: _____ Phone: _____

SECONDARY INSURANCE INFORMATION:

Insured's Name:_____ Insured's Employer: _____

Insurance Company:_____ Policy #: _____

Certificate or I.D. #: _____ Phone: _____

INFORMATION FOR PATIENTS

Dr. Arun Narang and his professional associates provide professional dental services on behalf of Dr. Arun Narang Dentistry Professional Corporation ("Narang PC"). Veenarun Health Facility Ltd operated by members of Dr. Narang's family under a cost sharing arrangement with Narang PC. Although Veenarun is not a health profession corporation, all dental hygiene services are provided under the clinical supervision of Dr. Arun Narang and his professional associate

☐ Smile by design
4-3038 Hurontario St
Mississauga ON L5B 3B9
905-897-1166

☐ Oakville Dental Arts
400-1344 Cornwall Road
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905-337-3511

☐ Limelight Dental
2-4188 Living Arts Drive
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905-949-2220

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DR ARUN NARANG DENTISTRY PROFESSIONAL CORPORATION

DENTAL HISTORY

Is the child currently in pain? Yes:____ No:____ What is the primary reason for today's visit?_____

Has the child experienced problems with previous dental work? Yes:____ No:____
Does the child brush his/her teeth daily? Yes:____ No:____
Floss his/her teeth daily? Yes:____ No:____

Previous/Present Dentist:_____Date of Last Visit:_____

Why did you leave your previous dentist? _____

What did you like the most about any dentist you have seen?_____Least?_____

Does/did the child have any of the following habits? (Please Circle)

Lip sucking/Biting	Clenching/Grinding teeth	Tongue/Cheek Biting	Mouth Breather
Nail biting	Thumb/Finger Sucking	Used pacifier	Speech Problems
Chewing on Objects	Nursing bottle habits	Tongue thrust	Breast Feeding

MEDICAL HISTORY

Child's Physician: _____ Phone:_____ Date Last Visit:_____

Address: _____
Street City Province Postal code

Is the child currently under the care of a physician? Yes:___ No:____ Please explain: _____

Please describe the child's current physical health: Good Fair Poor **Are Immunizations Current?** Yes:___ No: ___

Please list all drugs that the child is currently taking: _____

Please list all drugs and /or things that cause the child ALLERGIC reactions: _____

Is there anything would you would like to discuss with the Doctor in private? Yes:__ No: ___

Has the child had/experienced any of the following? (Please Circle)

Abnormal Bleeding	Congenital Heart Defects	High Blood Pressure	Rheumatic Fever
HIV/AIDS	Convulsions	Hives	Scarlet Fever
Allergies	Diabetes	Kidney Problems	Sickle Cell Anemia
Anemia	Epilepsy	Liver Problems	Skin Rash
Any Hospital Stay/Operations	Handicaps/Disabilities	Low Blood Pressure	Tonsillitis
Asthma	Hearing Impairment	Lupus	Tuberculosis
Blood Transfusion	Heart Murmur	Measles	
Cancer	Hemophilia	Mitral Valve Prolapse	
Chicken Pox	Hepatitis	Mononucleosis	

Please discuss any serious medical problems the child experiences/-ed:_____

AUTHORIZATION: I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor all insurance benefits. I understand that i am responsible for payment of services rendered any deductible and co-payment that my insurance does not cover.

_____ _____
Patient, parent or guardian signature Date

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PATIENT PRIVACY CONSENT FORM

For Collection, Use and Disclose of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collection, 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, the Privacy Information Officer is: Dr Arun K. Narang

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.

In 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 protocols
- Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law

Please do not hesitate to discuss our office policies with Dr. Arun Narang or any member of our team by surface mail/fax/email. Please be assured that every staff person in our office is committed to ensuring that you receive the best quality 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 below 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
- To communicate with other treating health-care providers, including specialists and referring doctors
- 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, are and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies 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 governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- 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 office'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

CONTINUE TO NEXT PAGE

CONTINUED:

By signing the consent section of the Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of you personal information for the purposes that are listed. If a new purpose arises for the use and/pr disclosure of you personal information, we will seek you approval in advance.

Your information may be acc4ess by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defence 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 you specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advice you if such a release is inappropriate.

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 as to see the Code at any time.

I agree that Dr. Arun Narang Dentistry Professional Corporation can collect, use and disclose personal information about

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

Questions: If you have any questions, please contact the Privacy Officer Dr. Arun Narang at 905-897-1166 ext 56.

"I acknowledge that I have received the full Privacy Notice."

Name (print)	Signature	Date
Witness (print)	Signature	Date

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FINANCIAL ARRANGEMENTS

WELCOME TO OUR PRACTICE:

We would like to introduce you to our practice philosophy and commitment, which is shared by every member of our friendly and professional dental team. We offer our assurance of cleanliness and your safety, cutting edge technology, a relaxed and caring environment, with a dental team that is unconditionally dedicated to caring for our patients with the highest of quality and comfort. After all…"teeth are for a lifetime and deserve the best possible care."

FINANCIAL ARRANGEMENTS:

We charge our fees according to the current Ontario Dental Association Fee Guide.

OPTIONS:

Please circle:

A)

1. **CASH**
2. **VISA, MasterCard, AMEX #** _____ **expiry date:** _____
3. **INTERAC**
4. **CHEQUE** (accompanied with SIN #, Driver's License & Credit Card back up)

B)

I wish to apply for your in-office **FUNDING PLAN (Medi-card or Care Credit)**; I understand that upon approval, I will make 12 equal monthly payments.

I understand that I am responsible for the payment of my dental treatment, at the time service is rendered, regardless of insurance coverage, including any legal or other costs incurred in the collection of this account, if it becomes delinquent.

_____	_____	_____
Date	Signature	Staff Member

*Please note **5% Pre-payment** courtesy is applied to your account when major; implant and cosmetic services are not covered by insurance and paid in full when scheduling the appointment. (At least 2 business days prior to appointment)

*Also note a **2% interest charge** per month is applied on overdue accounts (over 30 days). A $30.00 service charge is applied on any **NSF/Returned Cheques**.

FINANCIAL POLICY ARRANGEMENTS FOR ASSIGNMENT PATIENTS:

Please check the two boxes below:

"I have dental insurance and would like you to bill my insurance directly…" If you have dental insurance and your policy does not cover a procedure at 100%, you are responsible to pay any known differences, such as: deductible, fee guide differences, co-payments...etc. The differences are to be paid on the day of treatment. It is your responsibility to establish what percentage of the proposed treatment is covered by your dental plan. Your insurance company will only give our office basic information. If you, the patient, receive the insurance payment you will promptly bring it in and sign it over.

"Please bill me for any unknown differences that may occur…" I will pay known differences on the day of treatment

_____	_____	_____
Date	Signature	Staff Member

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CANCELLATION POLICY

RESTORATIVE AND HYGIENE APPOINTMENTS

We ask for ***at least 48 hours advance notice*** for cancelling or rescheduling an appointment; otherwise, a ***$50.00 & UP*** fee may be assessed to your account.

Note*:* All cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and times to properly complete your treatment. A broken appointment is a loss to three parties- the patient who missed the valuable time, the patient who could have taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

_____ _____

Signature Date

ACKNOWLEDGEMENT AND RELEASE

Insurance

We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist's treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company; therefore we do not confirm insurance eligibility or predetermine recommended treatment. We are not preferred providers or members or have any association with any insurance organizations.

Collections

In the event the balance becomes ***more than 60 days overdue***, billing may be turned over to an outside collection agency. The responsible party listed above aggress to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

_____ _____

Signature Date

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