



Welcome to Our Office!

OUR MISSION

Dr. Sukhman and her Team of caring and educated professionals are dedicated to providing our patients with the highest level of dental care. Dentistry is our passion and helping people improve their oral health and get the dental care they deserve in a relaxing and safe environment is our mission.

Dr. Sukhman Chauhan graduated in 2008 from dental school in India. She moved to Canada a couple of years after graduation and successfully completed the dental program at the University of Toronto. After graduation, she worked in the GTA and Northern Ontario which provided her an opportunity to work with people from diverse cultures and backgrounds. Coming from a smaller town in India, she always wanted to settle down in a smaller community away from the busy lifestyle of the Toronto area.

Dr. Sukhman really loves dentistry and she often refers to the dental office as “my happy place”. She is passionate about helping her patients improve their oral health by spending the time to know them better and understand their needs. She understands that dental visits can be stressful and will do her best to make them as comfortable as possible. She often talks about her personal experiences with patients and likes to hear about their unique experiences as well. Dr. Sukhman is excited to get involved in the community and raise her family in Muskoka.

So that we can prepare for your initial visit, please take a moment and complete the following forms in advance on line or return them by: fax to 705-788-2956 or email to hello@canoedental.ca

If you have further question, please contact us at 705-788-3067 or hello@canoedental.ca. If there is anything that we can do to make your experience more enjoyable, don't hesitate to ask! We appreciate the opportunity to help you achieve and maintain your oral health and smile!

***Canoe Dental
Suite 6 – 110 North Kinton Ave.
Huntsville, On
P1H 0A9
705-788-3067
705-788-2956 (fax)
hello@canoedental.ca***



Name: _____ Date of Birth (d/m/yr): _____
 Address: _____
 City/Prov: _____ Postal Code: _____
 Home #: _____ Work # _____
 Cell #: _____ Email: _____
 Family Doctor: _____ Phone #: _____
 Emergency Contact: _____ Phone #: _____
 Who is responsible for decisions relating to your treatment? Self? _____ Parent/Guardian? _____
 Who is responsible for financial matters for this account? Self? _____ Parent/Guardian? _____ Other? _____
 This account will be paid by: Cash _____ Debit _____ MasterCard _____ Visa _____ Amex _____
 Insurance company (if applicable): _____
 Policy#: _____ Certificate #: _____

The following information is required to enable us to provide you with the best possible dental care. Please complete the entire form. All the information is strictly private, and is protected by doctor-patient confidentiality. We will review and explain any questions that you do not understand.

Medical History:

1. Are you presently under the care of a physician? Why? _____ Yes No
 2. When was your last medical checkup? _____
 3. Has there been any change in your health in the past year? If yes, please explain. _____ Yes No
 4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? _____ Yes No
 5. Do you have any allergies? If yes, please explain _____ Yes No
 6. Have you ever had a peculiar or adverse reaction to any medications or injections? _____ Yes No
If yes, please explain: _____
 7. Do you have or have you ever had any of the following? (please circle yes or no for each)
- | | | | | | |
|-------------------------|-----|----|--------------------------|-----|----|
| Angina | Yes | No | Heart Murmur | Yes | No |
| Arthritis/Rheumatism | Yes | No | Hepatitis | Yes | No |
| Artificial Joints | Yes | No | High/Low Blood Pressure | Yes | No |
| Asthma | Yes | No | HIV/Aids | Yes | No |
| Bleeding Disorder | Yes | No | Kidney Disease | Yes | No |
| Cancer | Yes | No | Liver Disease | Yes | No |
| Cardiovascular Problems | Yes | No | Lung Disease | Yes | No |
| Diabetes | Yes | No | Mental/Nervous Disorders | Yes | No |
| Drug/Alcohol Dependency | Yes | No | Smoke/Chew Tobacco | Yes | No |
| Epilepsy | Yes | No | Stroke | Yes | No |
| Head/Neck Injury | Yes | No | Thyroid Disease | Yes | No |
| Headaches | Yes | No | Tuberculosis | Yes | No |
| Heart Problems/Attack | Yes | No | | | |
8. Are there any conditions or diseases not listed above that you have had? If yes, what _____ Yes No
 9. Are you nervous during dental treatment? _____ Yes No
 10. Are you pregnant? Yes No Due Date? _____ Breast Feeding? Yes No

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

Patient/Guardian: _____ Date: _____

Dentist: _____ Date: _____



Getting to Know You

Our practice places a strong emphasis on getting to know you and using that information to assist us in developing your personalized dental plan. Please answer the following questions:

What specific concerns would you like addressed?

How do you feel about the present health of your mouth?

How did you hear about our office?

Do you need treatment completed by a certain date?

Are there any obstacles you foresee in receiving dental care?

Is there anything about the appearance of your teeth that you would change?

What caused you to leave your last dentist?

Is there any additional information you would like us to know?
(past dental experiences good or bad, specific fears, etc)



Patient Consent Form Collection, Use and Disclosure of Personal Information

We understand the importance of protecting your personal information. All team members who come into contact with your records are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate use and proper protection of your information.

In this office, Dr. Sukhman acts as the privacy Officer.

Outlines of what the consent entails and what our office is doing to ensure your privacy are as follows:

- 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 as outlined by the Royal College of Dental Surgeons

Do not hesitate to discuss our policies with Dr. Sukhman or any member of our team.

How Our Office Collects, Uses and Discloses Patient's Personal 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 and provide care
- to offer, advise and provide treatment options, care and services in relationship to the oral and maxillofacial complex and dental care
- to establish and maintain communication with you, including booking and confirming appointments
- to communicate with other treating healthcare providers, including specialists and general dentist who are the referring dentists and/or peripheral dentists to allow us to efficiently follow up for treatment, care and billing
- for teaching and demonstrating 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 patient 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 patient's 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 and/or conduct and audit in preparation for the 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 Professionals Appeal and Review Board
- to process credit card payments and collect unpaid accounts
- to assist this office to comply generally with the law and all necessary regulatory requirements

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 your personal information for purposes that are listed. 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 the regulatory authorities under the terms of the *Regulated Health Professionals 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 that this request is made, we will forward the information directly to you for review, and for your specific consent.

Patient Consent

I have reviewed the above information and the description on how my information is protected by the Privacy policy and the steps the office is taking to protect my information. I understand that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Dr. Sukhman may collect, use and disclose personal information about _____ (patient name) as set out above in the office's privacy policies.

Print Name

Signature

Date

Witness



Financial Policy

Payment is expected in full at the time of service. We offer a number of payment options for your convenience:

1. Credit Card – Visa, MasterCard, AMEX
2. Cash
3. Debit
4. DentalCard (financing partner on approved credit)

For those patients with insurance, your benefits are based on a contract negotiated between your employer and the insurance company and are not intended to cover all dental treatment. While we will make every effort to maximize your benefits, we do not accept insurance cheques as payment. On your behalf, we will file your claim and the insurance payment will come to you directly, usually in less than one week.

Insurance companies will often only provide coverage for the least expensive treatment alternatives which are not necessarily in our patients' best interest. While you will always have the choice of what level of care you receive within our office, we will provide you with all options and suggest what we think is the best treatment for you and your family based on our clinical findings, not based on what we expect an insurance company to cover.

Cancellation Policy

Your appointment is a time reserved especially for you. It is your responsibility to record this reserved time for future reference. As a courtesy, we will remind you of appointments by phone or email as the date approaches. We require 48 hours notice, during business hours, to change or cancel an appointment. Late notice or missed appointments may be subject to a minimum \$50 charge.

I have read and understood this financial policy and am aware of my responsibility for payment the day services are provided.

Signature

Date



Important Information Regarding Insurance Benefits

It is vitally important that our patients understand the role that insurance has in their oral health.

First, insurance should only be considered a benefit to assist in the cost of dental care and not universal coverage. It is simply a contract between the insurance company and the employer that determines what benefit can be paid towards dental treatment. There are literally thousands of different plans, and while we can often inquire on your behalf, it is ultimately your responsibility to know the terms of the contract – your benefits coordinator would be the ideal person to contact if you are unsure of the details.

We want to make it very clear that insurance companies are in business for profit. They say and do many things to interfere with the relationship between the patient and the dentist. They do not look out for our patient's best interest, and they often attempt to interfere with our ability to provide high quality dental treatment.

One very common example is, "The patient is eligible for 9 month recall."

In this case the insurance company makes it seem like you are only eligible for cleanings every nine months. In almost all cases, this nine month interval only applies to the check up with the dentist. There are usually provisions that will pay for additional cleaning visits in between check ups, as nine months is too long a period for almost all adults to maintain their periodontal/gum health.

There are limitations in all benefit plans for what the employer will cover from annual maximums, to limited coverage on 'major' procedures, to providing coverage for only the least expensive alternative for treatment. Again, when a patient receives notices from the insurance company, it is often confusing, and the patient can be led to believe that if a procedure is not covered, then it might be unnecessary. Nothing could be further from the truth, and by rejecting proposed dental treatment, it lines the pockets of the insurance company, and provides obstacles to you receiving the quality of care that you deserve.

In our practice, the patient is always in control of deciding which treatment they wish to receive. If you wish to have only dental care that is covered by your plan, it is your responsibility to make this very clear to us, and we will do our best to stay within the confines of your benefits. However, it is our responsibility to let you know that in many cases, by limiting the level and amount of care that you are receiving, that the outcome of treatment often become less predictable.

Initial _____