bloorwestvillage
PERIODONTICS

DR. ELLY TEHRANI

We are pleased to welcome you to our office and look forward to meeting you on your scheduled appointment. Our goal is to help you achieve the highest level of optimal dental health, comfort, function and appearance that that meet your goals.

To respect your time, our appointments are carefully planned. Please expect to spend approximately 1 to 1 ½ hours with us at your initial visit. This ensures our ability to spend quality time with you and assist in your dental decisions. In most cases at this visit, future appointments will be determined, estimated fees discussed, and financial arrangements reviewed. So we may address all your questions we encourage you to invite your spouse, friend, or family member to accompany you to this important appointment. **This is especially valuable if this person will be actively involved with your treatment decision making process**.

It is generally our goal to complete the examination and consultation in one appointment. For patients whose treatment need are more complex, however, a secondary consultation appointment may be scheduled at a nearby date.

For the examination appointment, we request payment in full for the visit and any records that are necessary. Though we do not accept reimbursement from your dental benefits plan at the initial visit, we will be happy to submit to your carrier for reimbursement to you. As a courtesy to our patients, we will submit claims for subsequent treatment completed during your therapy.

In order to expedite your registration process at the first appointment, we have enclosed a new patient questionnaire, directions and parking for our office and a copy of our Privacy Policy with Acknowledgement of Receipt.

Please print and complete all of the forms as thoroughly as possible and bring them to your appointment. The insurance worksheet should be completed with the information for the party to whom the insurance is issued. Please feel free to contact our office if you have any questions about the appointment or any of the requested information.

It is our desire to provide you with quality care in a safe, pleasant and comfortable environment. We appreciate the interest you have shown in giving us the opportunity to serve your dental needs. We are looking forward to meeting you soon.

To Your Health

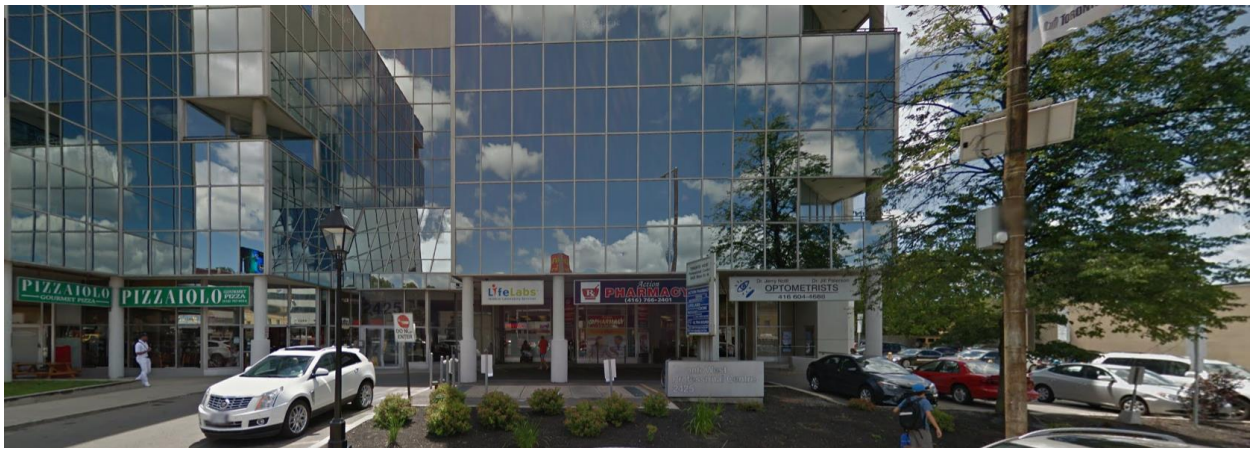
Elly Tehrani

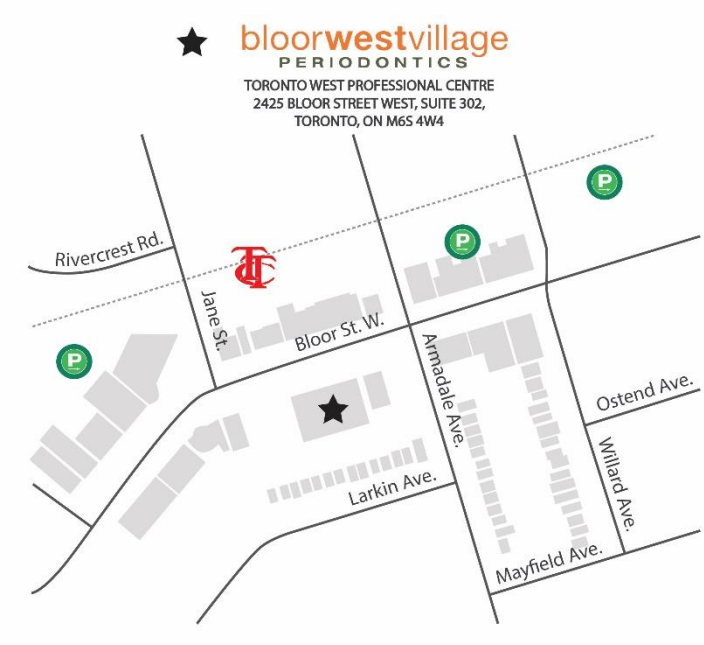
Hon. B.Sc., D.M.D., M.S.D., Cert. Periodontics., F.R.C.D.(C), ABP Dip., F.I.C.O.I.
Fellow, Royal College of Dentists of Canada
Diplomate, American Board of Periodontology
Fellow, International Congress of Oral Implantology

2425 Bloor Street West Suite 302 Toronto ON M6S 4W4
t:416.769.0711 | f:416.769.4868 | e:info@bwvperio.com | w:bwvperio.com

Directions and Parking

We are located at on south side of Bloor Street West just east of Jane Street. Our building is located across the street from the Jane Street TTC Station.





From the North: Take Hwy 404 South to the Don Valley Pkwy S. Then take Gardiner Expy W to S Kingsway exit. Continue on S Kingsway to Bloor. We're on the right, past the Jane St. lights.

From the East: Take Gardiner Expy W to S Kingsway exit. Continue on S Kingsway to Bloor. We're on the right, past the Jane St. lights.

From the West: Take Gardiner Expy E to S Kingsway exit. Continue on S Kingsway to Bloor. We're on the right, past the Jane St. lights.

Please contact us at **416-769-0711** if you need any assistance with directions or parking to our office.

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PERIODONTICS

Dr. Elly Tehrani, HBSc, DMD, MSD, Dip. ABP, FRCD(C)

NEW PATIENT QUESTIONNAIRE

PERSONAL INFORMATION

Dr./Mr./Mrs./Ms. Date _____

Name _____
Last First Initial

Address _____
Street City Prov. Postal Code

Phone (home) _____ (work) _____ (cell) _____

Contact Preference ☐ home ☐ work ☐ cell

Email _____

Emergency Contact _____ Tel. # _____

Family Physician _____ Tel. # _____

Referring Dentist _____ Tel. # _____

Whom may we thank for referring you to our office? _____

Reason(s) for visit _____

ACCOUNT INFORMATION

Person responsible for the account ☐ SELF ☐ SPOUSE ☐ OTHER_____

If other, please complete the following:

Name _____
Last First Initial

Address _____
Street City Prov. Postal Code

DENTAL INSURANCE INFORMATION

Primary Dental Benefit Provider:

Employer of Insured _____

Ins. Company Name _____

Subscriber ID#: _____ Group # _____

Subscriber Name: _____ DOB _____

Secondary Dental Benefit Provider:

Employer of Insured _____

Ins. Company Name _____

Subscriber ID#: _____ Group # _____

Subscriber Name: _____ DOB _____

****** Please bring your dental insurance card(s) with you to your appointment. ******

Please be advised that insurance companies will only provide benefit information to the subscriber, it is therefore your responsibility to know your dental benefits. For services not covered by your benefits, we accept cash, debit or most major credit cards. We do ask for payment at the time of service.

MEDICAL HISTORY

Since periodontal disease is caused by a combination of many complex elements, it is necessary to identify all possible contributing factors. The success of therapy is most dependent upon this. Though some of the following questions may seem unrelated to your condition, they can all be associated with proper management of your oral health. Your answers are for our records only and will be considered confidential.

		YES	NO
1.	Are you in good health? …….....	___	___
2.	Date of last physical examination _____ Are you currently being treated by a physician? ……	___	___
3.	Are you taking any prescription drugs or medication? ……..	___	___
	If yes, please list: _____		
4.	Are you taking any over-the-counter preparations or medications (example: aspirin, vitamins)? …….....	___	___
	If yes, please list: _____		
5.	Are you allergic to latex or any other medications or substances? …….....	___	___
	If yes, please list: _____		
6.	Have you had any serious illness, operation, or been hospitalized? ……..	___	___
	If yes, please explain: _____		
7.	Indicate which of the following you have had or have at present:		

	Yes	No		Yes	No		Yes	No
AIDS/HIV positive	___	___	Diabetes	___	___	Immune disorder	___	___
Alcohol addiction	___	___	Drug addiction	___	___	Hypoglycemia	___	___
Allergies of hive	___	___	Emphysema	___	___	Kidney disorder	___	___
Anemia	___	___	Epilepsy/seizures	___	___	Liver disorder	___	___
Angina	___	___	Fainting/dizziness	___	___	Mental disorder	___	___
Anxiety	___	___	Gastric reflux	___	___	Other joint replacement	___	___
Artificial heart valve	___	___	Glaucoma	___	___	Osteoporosis	___	___
Arthritis or rheumatism	___	___	Heart disease/attack	___	___	Prolonged bleeding	___	___
Asthma	___	___	Heart pacemaker	___	___	Radiation treatment	___	___
Blood disorder	___	___	Heart surgery	___	___	Sinus trouble	___	___
Cancer	___	___	Hemophilia	___	___	Stroke	___	___
Chemotherapy	___	___	Hepatitis	___	___	Thyroid disease	___	___
Cold sores	___	___	High blood pressure	___	___	Venereal disease	___	___
Congenital heart lesion	___	___	Hip/knew replacement	___	___	Ulcers	___	___

8.	Do you have any disease, condition, or problem not listed? ……..	___	___
	If yes, please explain: _____		
9.	Do you currently or have you in the past taken Foxomax, Actonel, Boniva, or Reclast for osteoporosis or were treated with the medications Zometa or Aredis for chemotherapy? ……	___	___
10.	Do you take any blood thinners (example: aspirin, warfarin, coumadin)? ……..	___	___
11.	Do you currently smoke or use smokeless tobacco? ……..	___	___
12.	Have you previously smoked or used smokeless tobacco? ……	___	___

WOMEN

13.	Are you pregnant or expecting pregnancy? ……..	___	___
14.	Are you taking birth control pills?	___	___
15.	Have you reached menopause? ……..	___	___

DENTAL HISTORY

1. Please describe your present dental problem(s): _____

_____

		Yes	No
2.	Are you having any discomfort or pain? ……	__	__
	If yes, where? _____		
3.	Do you feel you have enough teeth to chew with? ……..	__	__
4.	Do your gums bleed when you brush or floss? ……	__	__
5.	Do you frequently have a "bad taste" in your mouth? ……..	__	__
6.	Are your teeth sensitive to hot, cold or sweets? ……..	__	__
7.	Does your jaw ache when you wake in the morning? ……..	__	__
8.	Have you ever had orthodontic therapy (braces)? ……	__	__
9.	Do you snore? …….	__	__
10.	Do you have gastric acid reflux? ……..	__	__
11.	Are you aware of any loose teeth? ……..	__	__
12.	Are you satisfied with the appearance of your teeth? ……..	__	__
	If no, why? _____	__	__
13.	If you have a removable partial plate or denture, is it comfortable for chewing and speaking? ……	__	__
	If not, would you be interested in a more "permanent" teeth? ……	__	__
14.	Has anyone ever spoken to you about the advantages of dental implants? ……	__	__
15.	Do you have any specific questions or concerns about your oral health? ……	__	__
	If yes, please explain: _____		
	_____		
16.	Have you ever had any previous periodontal (gum) therapy? ……	__	__
	If yes, what kind of therapy and when? _____		
	_____		
	_____		

RELEASE

I understand that accurate and complete diagnosis is an essential first step in my dental care and authorize Dr. Tehrani to perform diagnostic procedures as may be necessary to achieve an accurate and complete diagnosis. I also understand that effective diagnosis and treatment may necessitate the involvement of other health professionals in my care and therefore authorize Dr. Tehrani to:

1. Request my (or my child's) previous medical or dental records and/or
2. Release of my information concerning my (or my child's) health care, advise, and treatment to another dentist or physician with that has my consent

I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time of services rendered, unless financial arrangements have been made. I would appreciate the office's assistance in submitting to my insurance company for reimbursement. I authorize release of any information concerning my (or my child's) health care, advise, or treatment provided for the purpose of evaluating and administering claims for insurance benefits and securing payment for treatment.

_____ _____ _____

Print Name | Signature of patient (parent or guardian) | Date

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. Elly Tehrani 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 collect unpaid accounts
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

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. 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 that I can ask to see the Code at any time.

I agree that Dr. Elly Tehrani can collect, use and disclose personal information about [please print your name here] as set out above in the information about the office's privacy policies.

Patient Signature	Date
Signature of Witness	Date