905 DENTAL

PATIENT INFORMATION FORM

NAME_____
LAST MIDDLE FIRST

BIRTHDATE_____/_____/_____EMAIL_____
DAY MONTH YEAR

HOME TEL(_____)_____-_____CELL(_____)_____-_____WORK/OTHER(_____)_____-_____

ADDRESS _____

CITY_____**PROVINCE**_____**POSTAL CODE**_____

DRIVER'S LICENSE (**REQUIRED FOR PRESCRIPTIONS**) _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

- □ PATIENT_____
- □ SPECIALIST/DR_____
- □ INSTAGRAM
- □ GOOGLE SEARCH ENGINE
- □ WEBSITE
- □ FLYERS
- □ FACEBOOK
- □ OTHER_____

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

NAME	_____	RELATIONSHIP	_____
HOME PHONE NUMBER	(_____)_____-_____	CELL/OTHER	(_____)_____-_____
PHYSICIAN'S NAME	_____	PHONE NUMBER	(_____)_____-_____
SPECIALIST'S NAME	_____	PHONE NUMBER	(_____)_____-_____

PLEASE COMPLETE IF YOU HAVE DENTAL INSURANCE THAT YOU WISH FOR US TO SEND YOUR DENTAL CLAIMS TO.

I AUTHORIZE RELEASE TO MY BENEFITS PLAN ADMINISTRATOR AND THE CDA, INFORMATION CONTAINED IN CLAIMS SUBMITTED ELECTRONICALLY. I ALSO AUTHORIZE THE COMMUNICATION OF INFORMATION RELATED TO THE COVERAGE OF SERVICES DESCRIBED TO THE NAMED DENTIST.

EMPLOYER_____ PROVIDER_____ GROUP#_____ I.D#_____

SECONDARY
POLICY HOLDER NAME (If other than yours): _____D.OB._____

EMPLOYER_____ PROVIDER_____ GROUP#_____ I.D#_____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

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CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

Patient's Name_____
(LAST) (MIDDLE) (FIRST)

Physician's Name_____ Phone#_____ Date of Last Exam_____

Are you currently under a physician's care? ☐Yes ☐No If yes, Please explain:_____

Have you recently been hospitalized? ☐Yes ☐No If yes, Please explain:_____

What is your estimated overall general health? ☐Excellent ☐Good ☐Fair ☐Poor

Are you allergic to any of the following?

☐Aspirin, ibuprofen, acetaminophen
☐Tetracycline
☐Local Anaesthetic
☐Metals (gold, nickel, stainless steel)
☐Acrylic
☐Penicillin
☐Erythromycin
☐Codeine
☐Fluoride
☐Sulfa drugs
☐ Other If yes, please explain:_____

Do you have, or have you had, any of the following?

Heart problems	☐Yes ☐No	Neurologic problems	☐Yes ☐No
Heart murmur	☐Yes ☐No	Arthritis	☐Yes ☐No
Rheumatic fever	☐Yes ☐No	Viral infections and cold sores	☐Yes ☐No
Scarlet fever	☐Yes ☐No	Any lumps or swelling in the mouth	☐Yes ☐No
High blood pressure	☐Yes ☐No	Venereal disease	☐Yes ☐No
Low blood pressure	☐Yes ☐No	Hepatitis – type _____	☐Yes ☐No
A stroke	☐Yes ☐No	HIV/AIDS	☐Yes ☐No
Anemia	☐Yes ☐No	Tumor, abnormal growth	☐Yes ☐No
Emphysema	☐Yes ☐No	Radiation therapy	☐Yes ☐No
Tuberculosis	☐Yes ☐No	Chemotherapy	☐Yes ☐No
Asthma	☐Yes ☐No	Emotional or psychiatric treatment	☐Yes ☐No
Kidney Disease	☐Yes ☐No	Antidepressant medication	☐Yes ☐No
Liver Disease	☐Yes ☐No	Snoring or sleep apnea	☐Yes ☐No
Thyroid or parathyroid disease	☐Yes ☐No	Alcohol/Drug dependency	☐Yes ☐No
Hormone deficiency	☐Yes ☐No	Artificial prosthesis joint replacement	☐Yes ☐No
High cholesterol	☐Yes ☐No	Prolonged bleeding due to a slight cut	☐Yes ☐No
Diabetes	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Stomach or duodenal ulcer	☐Yes ☐No	Glaucoma	☐Yes ☐No
Digestive disorders	☐Yes ☐No	Head or neck injuries	☐Yes ☐No
	☐Yes ☐No	Epilepsy, convulsions(seizures)	☐Yes ☐No

Are you?

Taking dietary supplement	☐Yes ☐No	Often unhappy or depressed	☐Yes ☐No
Often exhausted or fatigued	☐Yes ☐No	FEMALE – taking birth control pills	☐Yes ☐No
Subject to frequent headaches	☐Yes ☐No	FEMALE – Pregnant	☐Yes ☐No
A smoker or smoked previously	☐Yes ☐No	MALE – Prostate cancer	☐Yes ☐No

Are you taking any other medication? ☐Yes ☐No If yes, Please list medication(s): _____

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Name of Previous Dentist:_____ Date of last exam: _____

Date of last cleaning:_____ Date of last x-rays: _____

I routinely see my dentist every: □3 mos. □4 mos. □6 mons. □12 mons. □Not routinely

How would you rate the condition of your mouth? □Excellent □Good □Fair □Poor

Any immediate concerns? _____

PERSONAL HISTORY

Have you had an unfavourable dental experience?	□Yes □No
Have you ever had complications from past dental treatment?	□Yes □No
Have you ever had trouble getting numb or reactions to local anaesthetic?	□Yes □No
Did you ever have braces, orthodontic treatment or had your bite adjusted?	□Yes □No
Have you had any teeth removed?	□Yes □No

SMILE CHARACTERISTICS

Is there anything about the appearance of your teeth that you would like to change?	□Yes □No
Have you ever whitened (bleached) your teeth? How? _____	□Yes □No
Are you self-conscious about your teeth?	□Yes □No
Have you been disappointed with the appearance of previous dental work?	□Yes □No

Rate your SMILE from 1 to 10? 1 2 3 4 5 6 7 8 9 10 (Love my smile)

BITE AND JAW JOINT

Do you/would you have any problems chewing gum?	□Yes □No
Do you/ would you have any problems chewing bagels or other hard foods?	□Yes □No
Have your teeth changed in the last 5 years, become shorts, thinner or worn?	□Yes □No
Are your teeth crowding or developing spaces?	□Yes □No
Do you have any problems with sleep or wake up with an awareness of your teeth?	□Yes □No
Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?	□Yes □No
Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking, popping)	□Yes □No
Do you have tension headaches or sore teeth?	□Yes □No
Do you wear or have you ever worn a bite appliance?	□Yes □No

TOOTH STRUCTURE

Have you had any cavities within the last 3 years?	□Yes □No
Are any of your teeth sensitive to hot, cold, biting or sweets?	□Yes □No
Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?	□Yes □No
Do you avoid brushing any part of your mouth?	□Yes □No
Do you feel or notice any holes (i.e. pitting) in your teeth?	□Yes □No

GUM AND BONE

Have you ever been diagnosed or treated for periodontal (gum) disease?	□Yes □No
Have you ever experience gum recession?	□Yes □No
Do you have any family history of periodontal disease?	□Yes □No
Do your gums bleed when brushing, flossing or eating?	□Yes □No
Do you find any of your teeth becoming loose?	□Yes □No
Have you ever noticed an unpleasant taste or odour in your mouth?	□Yes □No
Have you experienced a burning sensation in your mouth?	□Yes □No

Patient/Guardian's Signature:_____ **Date:**_____

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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. Samuel Schlesinger is 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 protocol complies 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 us 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.

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

- To deliver safe and efficient patient care
- To identify and 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 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 of the College in a timely fashion for regulatory and mentoring purposes
- To permit potential purchases, 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 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

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 defence of legal issues.
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 release is inappropriate.
You may withdraw your consent for use of disclosure of your personal information, and we will explain the ramifications of the 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 905 Dental can collect, use, and disclose personal information about _____and dependents_____
_____
_____as set out above in in the information about the office's privacy policies.

_____ _____
Signature Print Name

_____ _____
Date Signature of Witness