Welcome To Our Dental Office

In order to render optimum health service it is necessary to become acquainted with the vital information related to each patient. Of course all information is strictly confidential. Although some questions may seem unimportant at the moment they may be vital in case of emergency. Therefore PLEASE ANSWER EVERY QUESTION ON BOTH SIDES.

PERSONAL INFORMATION **Date:** ________/__________/___________
Day **Month** **Year**

Name Mr/Mrs/Miss/Ms ________________ Birthdate (D/M/YY) ________ Age ________

Address ________________ Home Phone ________________

City ________________ Work Phone ________________ Ext ______

Postal Code ________________ E-mail ________________

Employer ________________ Occupation ________________

Medical Doctor ________________ Phone Number ________________

Best Method of Contact? (circle) E-mail Home Phone Work Phone

Name of person responsible for this account ________________

Do you have dental insurance? ________________

Company Name ________________

Policy Number ________________

I.D. or Social Insurance Number ________________

How did you hear about our office? ________________

MEDICAL HISTORY

		YES	NO
1.	Have you ever had a serious illness, operation, or been hospitalized? If yes, explain ________________	☐	☐
2.	Are you under the care of a physician now? If yes, explain ________________	☐	☐
3.	Have you had a medical examination within the last year? If yes, when? ________________	☐	☐
4.	Are you taking any medication presently? If yes, list ________________	☐	☐

5. Do you have or have you ever had any of the following? (circle)

Rheumatic Fever	Liver Disease (Jaundice, Hepatitis)	Thyroid Disease
Heart Trouble	Kidney Disease	Lung Disease
High Blood Pressure	Diabetes	Asthma
Heart Murmur	Epilepsy	Blood Disorders
Venereal Disease	Radiation or X-ray Disease	Anemia
Mental or Nervous Disorder	Gastrointestinal Disease	Cancer
Joint Replacement	AIDS	Sinusitis

Other ________________

		YES	NO
6.	Do you have any allergies? If yes, list ______________________________________	☐	☐
7.	Are you allergic to any medicines or drugs? If yes, list ______________________________________	☐	☐
8.	Have you ever had freezing (local anaesthetic) in your mouth? If yes, have you had ill effects from it? ______________________	☐	☐
9.	Do you bleed abnormally?	☐	☐
10.	Do you bruise easily?	☐	☐
11.	Have you ever fainted? If yes, when? ______________________________________	☐	☐
12.	Do you have shortness of breath?	☐	☐
13.	Do you have any chest pains?	☐	☐
14.	Do your ankles ever swell?	☐	☐
15.	Have you gained or lost excessive weight recently?	☐	☐
16.	Have you ever taken cortisone or steroids?	☐	☐
17.	Is there any history of family disease? If yes, list conditions: ______________________________________	☐	☐
18.	Is there anything else that the dentist should know regarding your medical history?	☐	☐
19.	To the best of your knowledge, are you in good health?	☐	☐
20.	Do you smoke If yes, how many: ____	☐	☐

WOMEN

Are you pregnant? ☐ ☐

If yes, in what stage of pregnancy are you? __________________________

DENTAL HISTORY

1. Have you had a complete dental examination with a full series of dental X-rays within the past 3 years? ☐ ☐
2. What was the date of your last dental visit? ________________________
3. What was done? ____
4. Have you had any extractions? ☐ ☐
   If yes, did you experience prolonged bleeding after? ________________
5. Have you ever had any of the following dental treatments? (circle)

Root Canal	Orthodontics	Full or partial dentures
Periodontal (gums)	Crowns or Caps	Bridgework

6. Are you aware of bad breath or a bad taste in your mouth? ☐ ☐
7. Have you ever had a bad experience at the dentist? ☐ ☐
8. What is your present dental problem? ______________________________

PATIENT CERTIFICATION AND CONSENT

I, the undersigned, certify that all of the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information. I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

Patient (Parent/Guardian) Signature: ______________________________ Date: ______________

Please read it entirety and sign

Collection, Use, and Disclosure of Personal Information

Privacy of your personal information is essential in order for us to provide you with quality dental care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information 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 complies with existing legislation and privacy protection protocols**
- **Our privacy protocols comply with privacy legislation, standards, our regulatory body (The Royal College of Dental Surgeons of Ontario) and the law**

Please do not hesitate to discuss our policies with any member of our staff and be assured that we are committed to ensuring that you receive the best quality dental care.

How Our Office Collects, Uses and Discloses Personal Information

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

- **To deliver safe and efficient patient care**
- **High quality service**
- **To access your health care**
- **To advise you of treatment options**
- **To enable us to contact you**
- **To establish and maintain contact with you**
- **To offer and provide treatment care and services in relationship to oral and maxillofacial complex and dental care**
- **To allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments**
- **To efficiently follow-up for treatment care and billings**
- **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 patient' charts and records to eh Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provision of the Regulated Health Professions Act**
- **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 access liability and quantity damages, if any.**
- **To prepare materials for the Health Professional Appeal and Review Board (HPARB)**
- **To invoice for goods and services**
- **To process credit and payments**
- **To collect unpaid accounts**
- **To assist this office to comply withal regulatory requirements**
- **To comply generally with the Law**

By Signing this consent section of this Patient Consent Form, you have agreed that you have given your information consent to the collection, use and/or disclosure of your personal information for the pruposes 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 Regulatory Health Professions Act (RHPA) for the purpose of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RPHA, and for the defence of a legal issue.

Our office will not under any conditions supply your insures wit your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review and for your specific consent. When unusual requests are made we will contact you for permission to release such information. We may also advise you in such release is inappropriate.

You may withdraw your consent 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 North Harwood Dental can collect, use and disclose personal information about

____ as set out in the above information.
Please print

______________________________ ____________________
Signature Date