ARTIN
DENTAL OFFICE

CONFIDENTIAL INFORMATION QUESTIONNAIRE *Please Print*

Mr. Mrs. Ms. Miss. Dr.

Patient Surname_____First name_____, Initial_____

Sex: M / F Date of Birth(D/M/Y)_____Occupation_____

Address_____Apt._____City_____

Province_____Postal Code_____Employer_____school_____

Home Phone #_____Work Phone #_____Cell #_____

Email _____ Preferred method of Contact _____

Emergency Contact- Name_____Relationship _____

Home Phone#_____Work Phone #_____

Other family members at this office_____

Who can we thank for referring you to our office?_____

Insurance Coverage? Y / N Insurance Company_____

Subscriber Name_____ Relationship to patient_____

Subscriber Date of Birth(D/M/Y)_____ Policy #_____

Identification #_____ Division#_____

Secondary Insurance Coverage? Y / N Insurance Company_____

Subscriber Name_____ Relationship to patient_____

Subscriber Date of Birth(D/M/Y)_____ Policy #_____

Identification #_____ Division#_____

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance to its credit terms and policy. I consent to the taking of radiographs and photographs before, during, and after treatment and to the use of same by doctor in consultations and presentations.

Signature_____Date_____

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Medical History

Patient Name _____ Pref. name_____ Birthdate_____

Name of Physician, Address, phone #_____

Date of last physical exam _____Purpose_____

What is your estimate of your general health? (circle the one applies) Poor Fair Good

HAVE YOU EVER HAD THE FOLLOWING:

1. hospitalization for illness or injury	Y	N	20. Thyroid or parathyroid disease	Y	N
2. allergic reaction to			21. Hormone deficiency	Y	N
❒ aspirin, ibuprofen, acetominophen			22. High cholesterol	Y	N
❒ penicillin			23. Diabetes	Y	N
❒ erythromycin			24. Stomach or duodenal ulcer	Y	N
❒ tetracycline			25. Digestive disorders	Y	N
❒ codeine			26. Arthritis	Y	N
❒ local anaesthetic			27. Glaucoma	Y	N
❒ fluoride			28. Contact lenses	Y	N
❒ metals (gold, stainless steel)			29. Head or neck injuries	Y	N
❒ latex			30. Epilepsy, convulsions, seizures	Y	N
❒ any other			31. Viral infections and cold sores	Y	N
			32. Any lumps or swellings in the mouth	Y	N
			33. Hives, skin, rash, hay fever	Y	N
			34. Venereal disease	Y	N
			35. Hepatitis (type)	Y	N
3. Heart problems	Y	N	36. HIV / AIDS	Y	N
4. Heart murmur	Y	N	37. Tumor, abnormal growth, cancer	Y	N
5. Rheumatic fever	Y	N	38. Radiation therapy	Y	N
6. Scarlet fever	Y	N			
7. High blood pressure	Y	N	39. Chemotherapy	Y	N
8. Low blood pressure	Y	N	40. Emotional problems	Y	N
9. Stroke	Y	N	41. Psychiatric treatment	Y	N
			42. Antidepressant medication	Y	N
			43. Alcohol / drug dependency	Y	N
10. Artificial prosthesis (heart valve or joint)	Y	N	ARE YOU:	Y	N
11. Anemia or other blood disorder	Y	N	44. Presently being treated for any illness		
12. Prolonged bleeding due to a slight cut	Y	N	45. Often exhausted or fatigued	Y	N
13. Emphysema	Y	N	46. Subject to frequent headaches	Y	N
14. Tuberculosis	Y	N	47. A smoker (packs/day)	Y	N
15. Asthma	Y	N	48. Often unhappy or depressed	Y	N
16. Sinus problems	Y	N	49. Easily upset or irritated	Y	N
17. Kidney disease	Y	N	50. FEMALE – taking birth control pills	Y	N
18. Liver disease	Y	N	51. FEMALE – pregnant	Y	N
19. Jaundice	Y	N	52. MALE – have prostate disorders	Y	N

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment_____

List any medications taken within the last two years_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY

OR ANY MEDICATIONS YOU MAY BE TAKING

Patient Signature_____Date_____

Doctor's Remarks_____Doctor's Signature_____

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Dental History

Please note that prior to any treatment our office requires a complete medical and dental history. Knowing any health problems that you have and/or medications that you may be taking can avoid problems when treatment commences. Thanks for taking the time to answer these questions

PATIENT'S NAME _____ DATE OF BIRTH_____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT? WHAT WAS DONE? _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN? _____

PREVIOUS DENTIST (NAME, LOCATION, Tel #) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL X-RAYS TAKEN? IF SO, WHEN? _____

HOW OFTEN DO YOU BRUSH AND / OR FLOSS YOUR TEETH? _____

IS YOUR DRINKING WATER FLUORIDATED? _____

1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING? ...	Y	N	10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?.....	Y	N
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?.....	Y	N	11. HAVE YOU NOTICED ANY TEETH BECOMING LOOSE?.....	Y	N
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?.....	Y	N	12. DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	Y	N
4. DO YOU FEEL PAIN WITH ANY OF YOUR TEETH?.....	Y	N	13. HAVE YOU EVER HAD PERIODONTAL (GUM) TREATMENT?	Y	N
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	Y	N	14. HAVE YOU EVER WORN A BITE PLATE, NIGHTGUARD OR OTHER APPLIANCE?	Y	N
6. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES?	Y	N	15. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	Y	N
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING			16. HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	Y	N
PROBLEMS WITH YOUR JAW?.....	Y	N			
CLICKING OR GRINDING NOISES.....	Y	N			
PAIN (JOINT, EAR, SIDE OF FACE)	Y	N			
DIFFICULTY IN OPENING OR CLOSING	Y	N	17. DO YOU WEAR FULL OR PARTIAL DENTURES?..... IF YES, DATE OF PLACEMENT _____	Y	N
DIFFICULTY IN CHEWING	Y	N			
8. DO YOU HAVE FREQUENT HEADACHES?	Y	N	18. HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS?	Y	N
9. DO YOU CLENCH OR GRIND YOUR TEETH?.....	Y	N			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE?

_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

DATE _____ **SIGNATURE OF PATIENT OR PARENT IF MINOR**_____

DOCTOR'S COMMENTS SIGNATURE _____ Date _____

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DENTAL OFFICE

PRIVACY NOTICE FOR OUR DENTAL OFFICE-IN ACCORDANCE WITH PIPEDA

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 and provide health care
- To enable us to contact, establish and maintain communication with you (distribute health care information, book and confirm appointments)
- 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 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 patient charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, in accordance to the provisions of the Regulated Health Professions Act
- To permit potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the dentists' 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 been 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 the regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario (RCDSO) 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 question 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 the permission to release such information. We will also advise you if such a release is inappropriate.

Patient Consent

I have reviewed the above information that explains how our office will use my personal information, and the steps your office is taking to protect my information.

I am aware your office has a Privacy Code, and I can ask to see the code at any time.

I agree that **ARTIN DENTAL OFFICE** can collect, use and disclose personal information about _____ (patient name) as set out above in the information about the office's privacy policies.

_____ _____

(print name) (date)

_____

(patient signature)