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WELCOME TO OUR OFFICE

PATIENT INFORMATION AND MEDICAL HISTORY

ALL INFORMATION IS CONFIDENTIAL

PERSONAL INFORMATION

Patient's name_____ Age_____ Birthdate_____

Address _____ City_____ Postal Code_____

Home phone_____ Cell _____ School_____

Email address (es) _____

Mother's name_____ Employer_____ Business number_____

Mother's address (if different above) _____Other telephone #_____

Father's name_____ Employer_____ Business number_____

Father's address (if different from above) _____ Other phone #_____

Guardian's name _____ Telephone number _____

Guardian's address (if different from above) _____

Have we treated any other family member(s) at our office? _____

Dentist: _____ Last Exam_____ Physician_____

Dental insurance Yes ____No____ Orthodontic insurance Yes ____No____

Policy Holder_____ Employer: _____

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

DENTAL HISTORY

Treated by another orthodontist in the past? Yes ____No____ Please explain_____

Major falls/accidents involving teeth, face or head? Yes____ No____ Please explain_____

Any thumb/finger sucking habits? Yes ____No____ Until age? _____Other habits? _____

Any tooth clenching and/or grinding? Yes ____No____ Difficulty chewing food? Yes ____No____

Any TMJ (jaw) clicking or pain? Yes ____No____ Speech difficulties? Yes ____No____

MEDICAL HISTORY

Overall in good health? Yes ____No____ Any difficulty breathing through the nose? Yes ____No____

Have tonsils and/or adenoids been removed? Yes____ No____ Please explain_____

Allergies? _____Reaction to any medication? _____

Please list any medications patient is currently taking?_____

For what condition (s)? _____History of repeated colds/sore throat? Yes_____ No_____

Continuation on the back of this sheet

Please circle where applicable to the patient: ADHD, Arthritis, Asperger Syndrome, Asthma, Autism, Blood Disorder, Cancer, Diabetes, Epilepsy, Fainting, Hay Fever, Heart Condition, Intestinal Disease, Kidney Disease, Low Blood Pressure, Liver Disease, Lung Disease, Migraines, Thyroid Condition, Tuberculosis, Venereal/STD.

Others?(explain)_____

Please specify any conditions/diseases not listed in above that you have or have had _____

For women – Are you pregnant? _____

Does the patient require antibiotic coverage for dental procedures? Yes ____No____

If so, please specify heart problem _____

PATIENT CERTIFICATION AND APPROVAL

I the undersigned certify that all of the above medical information is true to the best of my knowledge and I have not omitted pertinent information.

Patient/Parent/Guardian signature: _____ **Date:** _____

Patient Acknowledgement and Consent

OFFICE POLICY FOR THE COLLECTION, USE AND DISCLOSURE OF PATIENT PERSONAL INFORMATION

As dental professionals we are required to comply with **Federal and Provincial Privacy Legislation, (PIPEDA) and (PHIPA).** In order to do so, each of our patients must sign a consent form acknowledging and allowing us to collect, use and disclose personal information according to specific guidelines. We understand the importance of protecting your privacy, and we are committed to collecting, using and disclosing your personal information responsibly. All staff members whom 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. We collect, use and disclose information about you for the following purposes:

- To assess your health needs and risks, and to provide safe and efficient orthodontic care.
- To enable us to contact and maintain communication with you to distribute health care information and to book and confirm appointments.
- To offer and to provide treatment, care and services in relationship to the mouth and jaws and dental care generally.
- To communicate with other treating health-care providers, including other specialists and general dentists, and/or referring dentists, physicians, pharmacists, and laboratory technicians.
- To allow us to efficiently manage your account, including invoicing for goods and services, obtaining debit and credit card payments, credit authorization purposes, and for collection of unpaid accounts.
- To complete and prepare orthodontic treatment estimates/claims for third party adjudication and payment.
- To comply with legal and regulatory requirements, including the delivery of patient's 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 permit potential purchasers, practice brokers or legal and financial advisors to evaluate the orthodontic practice.
- To deliver your charts and records to the orthodontist's insurance carrier to enable the insurance company to assess liability.
- For teaching and demonstrating purposes on an anonymous basis
- To assist this office to comply with all regulatory requirements and comply generally with the law.

I have reviewed the above information that explains why and how your office will collect, use and disclose my/my child's personal information, and have been given the opportunity to ask questions about the steps your office is taking to protect this information. I acknowledge and agree that the office Dr. Ross Fiore can collect, use and disclose personal information about me/my child for the purposes listed.

Patient or guardians signature _____**Date** _____