PERSONAL INFORMATION

TODAYS DATE: _____
□ Mr. □ Miss. □ Mrs. □ Dr.
Name: _____
Date of Birth: _____
DAY MONTH YEAR
Address (HOME): _____
_____
_____
Phone: _____
Email Address: _____
Occupation: _____
_____

IN CASE OF EMERGENCY, WE SHOULD NOTIFY
Name: _____
Relationship: _____
Day Time Phone: _____

Name of Family Doctor: _____
Phone or Address: _____
_____
_____
_____
How did you find out about our office?
_____

MEDICAL HISTORY QUESTIONAIRE

1. Are you being treated for any medical condition at the present or have you been treated within the past year? Is so, why? □ Yes □ No □ Maybe

_____

2. When was your last medical checkup? □ Yes □ No □ Maybe

_____

3. Has there been any change in your general health in the past year? If yes, please explain. ? □ Yes □ No □ Maybe

_____

4. Are you taking any medications, non-prescription or herbal supplements of any kind? If yes, please list. ? □ Yes □ No □ Maybe

_____

5. Do you have any allergies? If you answered yes, please list using the categories below. ? □ Yes □ No □ Maybe
a) Medications b) Latex/Rubber products c) Other e.g. Hay fever, food.

_____

6. Have you ever had or adverse reaction to any medications or injections? If yes, please explain. ? □ Yes □ No □ Maybe

_____

7. Have you ever been advised by your doctor to take antibiotics before dental treatment? ? □ Yes □ No □ Maybe

_____

8. Do you have or have you ever had any of the following? If yes, please explain. (Please circle)

Arthritis	Diet Pill Therapy	Lung Disease	Shortness of breath
Asthma	Drug Dependency	Pacemaker	Steroid therapy
Alcohol/Drug dependency	Kidney Disease	Prosthetic Heart Valve	Stomach Ulcers
Bleeding Problem	Leukemia	Prosthetic Joint	Stroke
Cancer Chest Pain	HIV/ AIDS	Radiotherapy	Thyroid Disease
Angina Diabetes	Liver Disease	Seizures (Epilepsy)	Tuberculosis

9. Are there any conditions or diseases not listed above that you have ☐Yes ☐No ☐Maybe
or have had? Is so, what?
_____
10. **For women only:** Are you breast feeding or pregnant? If pregnant, □ Yes □ No □ Maybe
what is the expected delivery date_____

DENTAL HISTORY QUESTIONAIRE

Please check YES or NO to each question. If you are unsure of a question, please consult with the dentist.
Is there a dental problem you would like treated immediately? □ Yes □ No □ Maybe
Date of last dental visit: _____ Date of last dental cleaning: _____
Date of last dental x-rays: _____ Name of your previous dentist/ dental office:_____
1. Have you been seeing a dentist regularly? □ Yes □ No □ Maybe
2. Do you have any major treatment done/pending from your last dental office? □ Yes □ No □ Maybe
_____
3. Do your gums bleed when brushing or eating, or do you suffer from pain or □ Yes □ No □ Maybe
swelling in the gums?
4. Are any of your teeth sensitive to heat, cold, sweets, or pressure? □ Yes □ No □ Maybe
5. Do you use dental floss, proxabrush, or stimudents? How often? □ Yes □ No □ Maybe _____
6. How often do you brush your teeth? _____
7. Do you feel like you have bad breath? □ Yes □ No □ Maybe
8. Please list your main dental concerns which you would like to address today:
1) _____
2) _____
3) _____
_____

OFFICE POLICIES:

There may be a monetary charge for appointments cancelled without at least 48 hours advance notice from the time of the scheduled appointment. We cannot guarantee appointments for patients who arrive more than 15 minutes late of their scheduled appointment.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowing omitted any
information. I give my permission to telephone or email me to discuss matters related to this form. I have had the opportunity to ask questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary, and I consent
to the release of this information. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I
assume responsibility for fees associated with these services.

X _____ _____

(Signature) Patient Parent Guardian (Print Name of Guardian)

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. Ariel Cohen 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 healthcare 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 healthcare 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 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 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.

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 I can ask to see the Code at any time.

I agree that MARKHAM 7 DENTAL can collect, use and disclose personal information About _____

PATIENT NAME

Relationship to patient: □ Self □ Parent □ Guardian

Signature_____ Print name_____ Date_____