PLEASE FILL IN ALL FIELDS

PATIENT INFORMATION A Parent or Guardian will be responsible for decisions relating my treatment YES ☐ NO ☐

Name:_____
First Initial Last

Date of Birth:____/____/____ Email:_____
D M Y

Cell Tel:_____ Home Tel:_____ Work Tel:_____

Address:_____
Street City Postal Code

Preferred method of contact: Home # ☐ Work # ☐ Cell # ☐ Email ☐

☐ I agree to be added to your Facebook page ☐ I agree to subscribe to your newsletter

Preferred time and day for appointment (check all that apply) ☐ Morning ☐ Afternoon ☐ Evening

☐ Monday ☐ Wednesday ☐ Friday ☐ Sunday
☐ Tuesday ☐ Thursday ☐ Saturday

Family Dr:_____ Tel:_____
Emergency Contact:_____ Tel:_____

How did you hear about us?

Referred by (Insert name) ☐ Patient _____ ☐ Family Doctor_____
☐ Bus Shelters ☐ Mobile Sign ☐ Advertising around Shoppers World Mall
☐ Convenient location ☐ Google/Search Engine ☐ Online Review_____
☐ www.tridont.com ☐ Web Marketing ☐ Other (specify)_____

INSURANCE INFORMATION

Do you have extended health or dental insurance? YES ☐ NO ☐
If yes, please provide your card to receptionist, they will make a copy for your file.

DENTAL HISTORY

1. What is the reason for today's visit?_____

2. When was your last dental visit?_____

3. Are your teeth sensitive to: ☐ Cold ☐ Sweets ☐ Heat ☐ Other_____

4. Do your gums bleed when: ☐ Brushing ☐ Flossing ☐ Never YES NO

5. Do your gums feel swollen or tender?_____ ☐ ☐

6. Do you have bad breath or a bad taste in your mouth?_____ ☐ ☐

7. Do you have food catch between your teeth?_____ ☐ ☐

8. Have you ever had local anaesthetic (freezing)_____ ☐ ☐
If yes, were there any complications? (Please specify) _____ ☐ ☐

9. Have you had any problems with previous dental treatments? Specify_____ ☐ ☐

10. Have you had any of the following: ☐ Bridgework ☐ Crowns or Caps
☐ Full or Partial Denture ☐ Orthodontic (Braces) ☐ Periodontal (Gums) ☐ Root Canal

11. Are you satisfied with your teeth?_____ ☐ ☐

12. Do you have Sleep Apnea?_____ ☐ ☐
If yes, are you using any of the following: ☐ CPAP machine ☐ Oral Appliance

MEDICAL HISTORY (this information will remain confidential) YES NO

1. Are you presently under the care of a physician? If so explain_____ ☐ ☐

2. Have you ever had a serious illness or been hospitalized? If so explain_____ ☐ ☐

3. Are you taking any Drugs or medication at this time? ☐ ☐

4. Do you suffer from any allergies (hay fever, latex, etc.)? If so which ones?_____ ☐ ☐

5. Do you bruise easily or have prolonged bleeding? _____ ☐ ☐

6. Have you ever fainted, had shortness of breath or chest pains_____ ☐ ☐

7. Have you ever been warned against using any medication? If so which?_____ ☐ ☐

8. Have you ever taken prolonged medical or non-medical drugs? Specify _____ ☐ ☐

9. Have you ever had an adverse effect to any of the following?

☐ Aspirin	☐ Barbiturates (sleeping pills)	
☐ Codeine	☐ Darvon	☐ Local Anaesthetic
☐ Antibiotics:	☐ Penicillin	☐ Sulfonamide

10. Women: YES NO

Are you pregnant?_____ ☐ ☐

Have you reached menopause? _____ ☐ ☐

Are you taking birth control? _____ ☐ ☐

11. Do you or have you ever had any of the following: Please check off appropriate circles

◯ A.I.D.S.	◯ Cancer	◯ Heart disease/attack	◯ Jaundice	◯ Rheumatic/Scarlet fever
◯ Anemia	◯ Circulation Problems	◯ Heart murmur	◯ Kidney disease	◯ Sickle cell disease
◯ Angina pectoris	◯ Congenital heart lesion	◯ Heart Pacemaker/surgery	◯ Liver disease	◯ Sinus Trouble
◯ Anorexia nervosa	◯ Cortisone/steroid	◯ Heart rhythm disorder	◯ Leukemia	◯ Stomach/intestinal prob.
◯ Arthritis/rheumatism	◯ Diabetes	◯ Hepatitis A/B/C	◯ Lung disease	◯ Stroke
◯ Artificial heart valve	◯ Drug/Alcohol dependence	◯ Herpes	◯ Malignant hyperthermia	◯ Thyroid disease
◯ Artificial joints (hip, knee)	◯ Emphysema	◯ High/Low blood pressure	◯ Mental/nervous disorder	◯ Tuberculosis
◯ Asthma	◯ Epilepsy or seizures	◯ H.I.V. positive	◯ Mitral valve prolapsed	◯ Ulcers
◯ Blood Disorders	◯ Glandular disorders	◯ Hodgkins disease	◯ Organ transplant/implant	◯ Venereal disease
◯ Bronchitis	◯ Glaucoma	◯ Hyper (Hypo) Glycemia	◯ Psychiatric treatment	◯ Other_____
◯ Bulimia	◯ Head/neck injuries	◯ Hypertension	◯ Radiation/Chemotherapy	◯ None

12. Children only: Have you recently had any of the following (approximate date)

☐ Chicken Pox	☐ Measles	☐ Mumps
☐ Strep Throat	☐ Tonsillitis	

GENERAL RELEASE: I, the undersigned, understand that the information contained in the dental and medical history portion of this chart is important to my treatment. I certify that all the information is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health provider as required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ☐ Patient ☐ Parent ☐ Guardian Print Name Date

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, **Ms Kathleen Goodman** 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 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.

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 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 with 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 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 by the office and/or third party.
- ✓ 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 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. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. 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 the Tridont Dental Centre can collect, use and disclose personal information about _____ as set out above in the information about the office's privacy policies.

_____ _____

Signature Patient/ Guardian Date

_____ _____

Print Name Date of Birth.

_____

Witness

Informed Consent for Periodontal Treatment

We feel it prudent to advise patients of the general nature of treatment procedures, the acceptable treatment alternatives, and the risks inherent in the proposed procedures.

I hereby request and voluntarily consent to periodontal treatment that has been recommended. I understand that the goal of this treatment is the removal of periodontal disease causative factors and to assist in the control of periodontal disease, which disease could result in eventual bone and tooth loss.

I understand that the nature of Treatment involves the charting and recording of existing conditions on an annual basis, or other previously discussed intervals, the removal of plaque, tarter and/or stain, and root planing- a controlled procedure to smooth and refine the root surface of the tooth.

The treatment has been fully explained to me including the risks involved. I have been informed that complications might include, but are not limited to:

There may be an unexpected sensitivity/allergy to the materials

Tooth sensitivity and gingival sensitivity

I further understand that the likely consequences of NOT having the treatment are the likelihood of progressing periodontal disease and eventual bone and tooth loss. This may include "gum abscesses"; periodontal infections involving the root area, leading to root canal therapy. Bone loss may result in the need for periodontal surgery and may result in eventual tooth loss

I have had an opportunity to ask questions of my treating doctor and am fully satisfied with the answers I have received.

Patient/Guardian_____ Date ___ _____

Witness _____ Date___ _____

In addition to the risks and benefits outlined above, I have been advised of the following:_____ _____