WATERDOWN SMILES
DENTISTRY

Patient Information

Patient Name: ____ Date: _____________ ☐ Male ☐ Female

(Last) (First)

☐ Married ☐ Single ☐ Child ☐ Other : ________________ Birth Date (dd/mm/yy):___________________________

Address:

____ ______ _________________________ _________________

(Street) (Apt#) (City/Province) (Postal code)

Phone (Home): (____)____-_______ (Work): (_____)____-________ Ext:_____ (Cell): (____)____-__________

Email address: ____

Occupation:

Emergency contact: ___________________________________ Number: _______________________________________

Relationship: ____________________________________

How did you hear about us: ____

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

Health Information

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____________ _____________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood disorders
- ☐ Cancer
- ☐ Diabetes Controlled? ☐ Yes ☐ No
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure Controlled? ☐ Yes ☐ No
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date: _________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumours
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Chest pain/Angina
- ☐ Drug/Alcohol Dependency

Other:
☐ _______________
____
____
____

Please list all prescription and non-prescription medications you are currently using:

______________________________ ___________________________
______________________________ ___________________________
______________________________ ___________________________
______________________________ ___________________________

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· Have you been admitted to a hospital or needed emergency care during the past two years?
☐ Yes ☐ No

If yes, please explain

· Are you currently under the care of a physician? ☐ Yes ☐ No

If "Yes", please explain: ____
____
____

Name & Number of family doctor or specialist:

- Do you smoke or use chewing tobacco products? ☐ Yes ☐ No
- How long have you been a smoker ________years
- How many cigarettes/day? __________________

- Do you drink alcohol? ☐ Yes ☐ No

If "Yes", how much and how often? ____

· Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: ____

Date of Last Dental Visit: _________________ Reason for this visit: ___________________________

· Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:

Have you been told that you snore or stop breathing when sleeping? ☐ Yes ☐ No

Do you get pain or clicking/popping sounds in your TMJ? ☐ Yes ☐ No

I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and to the best of my ability and that any questions that I may have had have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____
[Patient's Name]

____ ____________________
[Patient's Signature] [Date]

____ ____________________
[Doctor's Signature] [Date]

WATERDOWN SMILES
DENTISTRY

PATIENT CONSENT FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your and your personal information is an important part of our office providing you with quality dental care. Waterdown Smiles Dentistry understands 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.

All staff members at Waterdown Smiles Dentistry 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.

We have outlined what our office is doing to ensure that:

- Only necessary information about you is collected:
- We only share information with your consent
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols:
- Our privacy protection complies with privacy legislation, standards of our regulatory body, the College of Dental Hygienists of Ontario and/or the Royal College of Dental Surgeons of Ontario, and the law.

Please be assured that every staff member is committed to ensuring that you receive the best quality care, and please do not hesitate to discuss our policies with myself or any staff member.

Waterdown Smiles Dentistry will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and ensure continuous high quality service
- To assess your health needs and provide health care
- To advise you of treatment options
- To enable us to contact you and maintain communication with you, including distributing health-care information and to 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 physicians, pharmacists, referring general dentists and specialists
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstration 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 and/or the College of Dental Hygienists 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 Waterdown Smiles Dentistry and staff with the Royal College of Dental Surgeons of Ontario and/or the College of Dental Hygienists of Ontario, including the delivery and/or review of patients' charts and records to the college(s) in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the practice and potentially allow such people to conduct an audit in preparation for a practice sale

- To deliver your charts and records to the staff's insurance carriers 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 reading the consent sections 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 verbal and/or written 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 and/or the College of Dental Hygienists of Ontario fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Our office will not supply your insurance company with your confidential medical history information. If such a request is made, we will obtain specific request from you to forward such information along.

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 and 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 Waterdown Smiles Dentistry will use my personal information, and the steps your practice is taking to protect my information.

I know that your practice has a Privacy Code, and I can ask to see the Code at any time.

I agree that Waterdown Smiles Dentistry can collect, use and disclose personal information about myself and/or family as set out above in the information about the office's privacy policies.

_______________________________________   ____________________
[Patient's name]   [Date]

____
[Patient's Signature]

_______________________________________   _____________________
[Doctor's Signature]   [Date]