MEDICAL HISTORY QUESTIONNAIRE

MR./ MISS./ MRS./ DR.

NAME:

DATE OF BIRTH: (MONTH/ DAY/ YEAR) / /

ADDRESS (HOME):

CITY/POSTAL CODE

PHONE:

CELL PHONE:

EMAIL ADDRESS:

NAME OF EMPLOYER:

BUSINESS PHONE:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE:

PRIMARY DENTAL INSURANCE:

GROUP NUMBER:

CERTIFICATE OF ID NUMBER:

POLICY HOLDER:

DO YOU HAVE SECONDARY INSURANCE:

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.
Please fill in the entire form.

1. Are you being treated for any medical condition at the present, or have you been treated within the past year? If so, what and why?

❑ YES ❑ NO

2. When was your last medical checkup? When was your last dental visit?

3. Has there been any change in your general health in the past year? If yes, please explain.

❑ YES ❑ NO

4. Are you taking medication, non-prescription drugs or herbal supplements of any kind? If yes, please list.

❑ YES ❑ NO

5. Do you have allergies. If yes, please list using the categories below:

a) medications
b) latex/rubber products
c) other e.g. hayfever, foods

❑ YES ❑ NO

6. Have you ever had an unusual or adverse reaction to any medicines or injections? If yes, please explain.

❑ YES ❑ NO

7. Do you have or have you ever had asthma?

❑ YES ❑ NO

8. Do you have or have you ever had any heart or blood pressure problems?

❑ YES ❑ NO

9. Do you have or have you ever had a heart murmur, mitral valve prolapse or rheumatic fever?

❑ YES ❑ NO

10. Do you have a prosthetic or artificial joint? ❑ YES ❑ NO

11. Have you ever been advised by your doctor to take antibiotics before dental treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

12. Do you have any conditions or therapies that could affect your immune system e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy?

❑ YES ❑ NO

13. Have you ever had hepatitis, jaundice or liver disease? ❑ YES ❑ NO

14. Do you have a bleeding problem or bleeding disorder? ❑ YES ❑ NO

15. Have you ever been hospitalized for any illness or operations? If yes, please explain. ❑ YES ❑ NO

16. Do you have or have you ever had any of the following? Please check.

❑ chest pain, angina	❑ shortness of breath	❑ lung disease	❑ steroid therapy	❑ arthritis	❑ thyroid disease
❑ heart attack	❑ prosthetic heart valve	❑ tuberculosis	❑ diabetes	❑ seizures (epilepsy)	❑ diet pill therapy
❑ stroke	❑ pacemaker	❑ cancer	❑ stomach ulcers	❑ kidney disease	❑ drug/alcohol dependency

17. Are there any conditions or diseases not listed above that you have or have had? If so, explain.

❑ YES ❑ NO

18. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease)

❑ YES ❑ NO

19. Do you smoke or chew tobacco products? ❑ YES ❑ NO

20. FOR WOMEN ONLY: Are you breast-feeding or pregnant? If pregnant, what is the expected delivery date?

❑ YES ❑ NO

SCHEDULING AND CONSENT

This is to certify that I the undersigned consent to the performing of dental and oral surgery procedures agreed to be necessary and I will assume responsibility for the fees associated with those procedures. If I fail to cancel appointments without adequate notice of 24 hours, I understand there will be a charge.

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS CORRECT

PATIENT/PARENT/GUARDIAN SIGNATURE: DATE:

DENTIST SIGNATURE: DATE:

BRAMPTON FAMILY DENTAL

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.

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 **Brampton Family Dental** 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