Drs. Ling, Ferrao, Ling, Gravett, Sachania, Bennett, Leung & McIntosh

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Personal Information

○ Mr. ○ Mrs. ○ Ms. ○ Dr.

Name: _____ Date of birth: _____

Address: _____City:_____

Postal Code: _____ Home phone: _____

Work phone: _____ Cell Phone: _____

Email address: _____

In an effort to save paper, most of our patients enjoy the convenience of email and text messages for special announcements and appointment reminders. Your personal information is never shared with a third party. You can opt out of these green initiatives at any time.

Primary Coverage

Policy Holder: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Dental insurance company: _____

Policy #: _____ Certificate #: _____

Secondary Coverage

Policy Holder: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Dental insurance company: _____

Policy #: _____ Certificate #: _____

How did you hear about us? Please <u>select one</u> of the following:

- ○ ***Location/Signage***
- ○ ***Facebook***
- ○ ***Flyer in the Mail***
- ○ ***Flyer from a Friend***
- ○ ***Website***
- ○ ***Yellow Pages***
- ○ ***Newspaper Flyer***
- ○ ***Person:_____***
- ○ ***Other:_____***

Clarence Street DENTAL Group

www.clarencestreetdental.com

MEDICAL HISTORY

Family Physician: _____ Date of last exam:_____

Were any problems identified? ☐ YES ☐ NO If YES please explain:_____

_____

Have you ever been diagnosed with any of the following conditions?

☐ Allergies to anesthetics _____ ☐ Allergies to antibiotics _____

☐ Allergy to latex ☐ Other allergies _____

☐ Anemia	☐ Eating disorders, anorexia, bulimia	☐ Liver Disease
☐ Arthritis	☐ Emphysema	☐ Leukemia
☐ Asthma	☐ Gastrointestinal disorders	☐ Osteoporosis
☐ Bleeding or bruising	☐ Heart Murmur	☐ Pace Maker
☐ Cancer _____	☐ Heart Disease	☐ Psychiatric care
☐ Chemo /Radiation Treatment	☐ Heart Attack	☐ Rheumatic Fever
☐ COPD	☐ Hepatitis A/B/C, Jaundice	☐ Stroke
☐ Diabetes Type I/ Type II	☐ HIV Positive status/AIDS	☐ Stomach Ulcer
☐ Epilepsy or Seizures	☐ Kidney Disease	☐ Tuberculosis
☐ Prosthetic Joints Date of Surgery_____		☐ Other

Please list ***all medications*** **and** ***dosage*** and state **what each medication is taken for.** Please include all **'Over the counter'** or ***'Natural' supplements*** you take on a regular basis:

MEDICATION:	**CONDITION taken for:**	**MEDICATION:**	**CONDITION taken for:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has your doctor or dentist ever asked you to take antibiotic prior to your dental visits? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO How many cigarettes per day? _____

Are you Pregnant? ☐ YES ☐ NO Date you are due? _____

Do you have any other conditions that we should be made aware of?

_____

To the best of my knowledge, the above information is correct and complete.
This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to by myself and the dentist. I authorize the dentist to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and ensure my safe and proper treatment. I also understand that the responsibility for the fees associated with these procedures is mine.

Signed: _____ Date: _____

Dental History

What is your main concern? _____

_____

Date of last dental visit: _____ Previous dentist: _____

Reason for leaving previous dentist: _____

Do you have any history of:

Orthodontics ☐ No ☐ Yes _____

Oral surgery ☐ No ☐ Yes _____

Gum surgery ☐ No ☐ Yes _____

TMD ☐ No ☐ Yes _____

Headaches/migraines ☐ No ☐ Yes _____

Dentures ☐ No ☐ Yes _____

Are you completely happy with the shape, colour, and position of your teeth?

_____

Do you have any anxiety with dental treatment? Have you had bad experiences in the past?

_____

Do you have any other concerns you would like the doctor to address?

_____

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, Dr. Lee Ferrao 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 you 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 outline 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, and 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
- To complete and submit dental claims for third party adjudication and payment
- To communicate with third party regarding coverage and liability on proposed treatment
- 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 (RHPA)
- 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
- For teaching and demonstrating purposes on an anonymous basis
- 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 the 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 propose 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, ad for the defense of a legal issue.

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 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 Clarence Street Dental Group, and its successor, can collect use and disclose personal information about _____ (Patient's/Dependant's Name) as set out above in the information about the office's privacy policies.

_____ Signature

_____ Print Name

_____ Date

_____ Signature of Witness