PATIENT REGISTRATION **MEDICAL HISTORY**

WOLFEDALE MISSISSAUGA DENTAL CARE

Unit 2A - 848 Burnhamthorpe Road West
Mississauga, Ontario
L5C 2S3

Welcome to our Practice!

(For office use only)

I.D. #	
MEDICAL ALERT	Y ☐ N ☐

Date: _____

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form. *PLEASE PRINT.*

PATIENT INFORMATION

PATIENT IS AN: *ADULT* ☐ *CHILD* ☐ *ADULT UNDER GUARDIANSHIP* ☐ **NAME OF GUARDIAN :** _____

Name: _____ Nickname : _____ Mrs. ☐ Ms ☐ Mr. ☐
(last) (first) (initial)

Home Address _____
(street) (city) (prov.) (postal code)

Home Phone ( ) _____ Cellular Phone ( ) _____ Fax No. ( ) _____

Date of Birth: _____ Age : _____ Sex : _____ Marital Status : _____

Driver's License # _____ Social Insurance # _____

Family Physician : _____ Phone : ( ) _____

Medical Specialist (if presently under care) : _____ Phone : ( ) _____

OCCUPATION:

Employed By: _____ Phone : ( ) _____

Spouse Employed By: _____ Phone : ( ) _____

IN CASE OF EMERGENCY Please Notify: _____ Relationship : _____

Home Phone : ( ) _____ Business Phone : ( ) _____ Ext. _____

Is any other member of your family or relative a patient at our office? _____

REASON FOR TODAY'S VISIT Examination ☐ Emergency ☐ Other ☐ _____

Who may we thank for referring you to our office ? _____

FINANCIAL INFORMATION

Person responsible for account: Self ☐ Spouse ☐ Other ☐ ***Please complete all information if different than above***

Name : _____ Phone : ( ) _____
(last) (first) (initial)

Address : _____
(street) (city) (prov.) (postal code)

Employed by: _____ Phone : ( ) _____

Driver's Lic. No.: _____ Phone : ( ) _____

PRIMARY DENTAL INSURANCE (If information is available)					**SECONDARY DENTAL INSURANCE**				
Subscriber's name :		D.O.B.			Subscriber's name :		D.O.B.		
Emp./Grp.policy holder:		Ins. Yr. End			Emp./Grp.policy holder:		Ins. Yr. End		
Ins. Co.		Tel.			Ins. Co.		Tel.		
Grp./Ind. Policy no.		Cert. No.			Grp./Ind. Policy no.		Cert. No.		
I.D./S.I.N.		Max. Coverage			I.D./S.I.N.		Max. Coverage		
% coverage: Basic	Maj. Rest.	Perio	Endo	Prostho	% coverage: Basic	Maj. Rest.	Perio	Endo	Prostho

METHOD OF PAYMENT (for office use only) **CASH** ☐ **CHEQUE** ☐ **CREDIT CARD** ☐ **OTHER** ☐

MEDICAL ALERT	CONDITION	PRE-MEDICATION	ALLERGIES	ANAEST.

MEDICAL HISTORY — PLEASE CHECK YES OR NO, *IF NOT SURE*, CHECK NS	NO	NS	YES
Are you presently under Doctor's care? Why?			
Have you been under Doctor's care in the past two years? Why?			
Have you taken any medications, pills or drugs in the past two years?			
Are you presently taking any medications, pills or drugs?			
Have you ever had Tonsillitis?			
Have you been hospitalized in the past two years/ (if yes, why?)			
Have you had any type of surgery? What & When?			
When was your last complete physical examination?			
When walking, do you ever have to stop because of pain in your chest or shortness of breath?			
Are you on a prescription diet?			
Have you ever been diagnosed as having a tumor or cancer?			
Have you ever taken cortisone/steroid medication?			
Do you experience problems with healing?			
Do you smoke? (if yes, how much?)			
Are you currently in good health?			
Do you bruise easily or bleed excessively?			
Have you ever been warned about anaesthetic risks?			

ALLERGIES — *Please check off any medications you are allergic to or you have reacted adversely to:*

☐ Ibuprofen (Advil)	☐ Nembutal	☐ Demerol	☐ Ampicillin	☐ Rovamycin	☐ Local Anaesthetic (Freezing)
☐ Aspirin	☐ Seconal	☐ Percodan	☐ Erythromycin	☐ Cedhalexin	☐ Nitrous Oxide
☐ Tylenol	☐ Naproxen	☐ Darvon	☐ Clindamycin	☐ Sulpha Drugs	☐ Amoxicillin
☐ Tylenol #2, #3, #4	☐ Toradol	☐ Penicillin	☐ Scopolamine	☐ Metal	☐ Chlorhexidene (Peridex)
☐ 222, 282, 292	☐ Codeine	☐ Valium	☐ Tetracycline	☐ Latex	☐ Bandage

☐ **Food Allergies, please list:**

Please list any other medications or substances which you know you are allergic to:

MEDICAL CONDITIONS — *Please check off all of the following conditions you presently have, or have had. (If not sure, check NS)*

	No	NS	Yes		No	NS	Yes		No	NS	Yes
Malignant Hyperthermia				Scarlet Fever				Rheumatic Fever			
Stomach/Intestinal Problems				Kidney Trouble				Artificial Joints/Hips			
Transdermal Nicotine Patches				Ulcers				Diabetes or Hypoglycemia			
High Blood Pressure/Hypertension				Asthma				Arthritis/Rheumatism			
Low Blood Pressure				Hay Fever				Epilepsy or Seizures			
Heart Failure				Sinus Trouble				Glandular Disorders			
Congenital heart Lesion				Emphysema				Psychiatric Care			
Artificial Heart Valve				Frequent Cough				Mental/Nervous Disorders			
Heart Pacemaker				Lung Disease				AIDS (HIV Positive)			
Heart Surgery				Bronchitis				Venereal Disease			
Heart Murmur				Tuberculosis				Herpes			
Mitral Valve Prolapse				Liver Disease				Cold Sores			
Chest Pain				Hepatitis A (infec.)				Fever Blisters			
Angina Pectoris				Hepatitis B (serum)				Blood Disorders			
Shortness of Breath				Hepatitis C				Circulation Problems			
Stroke				Yellow Jaundice				Sickle Cell anemia			
Fainting or Dizziness				Thyroid Disease				Hemophilia			
Anemia				Glaucoma				Cancer			
Cardiac Arrest/Heart Attack				Pain in Jaw Joints				Chemotherapy/Radiation			
Swelling of Feet/Ankles/Hands				Head/Neck Injuries				X-Ray/Cobalt Treatment			
Drug or Alcohol Addiction →				→ If yes, have you received treatment?				Where?			

Is there anything we have not mentioned that you think we should know regarding your medical history?

Follow-up information to above questions:

WOMEN ONLY

Are you pregnant? Yes ☐ No ☐ — Are you taking Birth Control Pills? Yes ☐ No ☐

Are you nursing? Yes ☐ No ☐ — Are you taking Fertility Drug? Yes ☐ No ☐

CHILD PATIENT

Has he/she had any of the following recently ? (indicate approximate date)

Measles _____ Mumps _____ Chicken Pox _____ Strep Throat _____ Tonsillitis _____

Do you wish to speak privately with the Doctor about any problem?

DENTAL HISTORY

MEDICAL UPDATES

MEDICAL ALERT	CONDITION	PRE-MEDICATION	ALLERGIES	ANAEST.

PATIENT NAME:	CHART NO.:	DATE:

REASON FOR INITIAL VISIT:

LAST DENTAL VISIT:	LAST DENTAL CLEANING:	PREVIOUS DENTIST:
Date : _____ \ _____ \ _____ M D Y	Date : _____ \ _____ \ _____ M D Y	

Please check YES or NO., If not sure, please check NS.

	No	NS	Yes
Are you suffering from pain now?			
Are any of your teeth becoming loose?			
Have any of your teeth shifted?			
Does food get caught between your teeth?			
Are any teeth sensitive to : cold ☐ hot ☐ Biting ☐ pressure ☐ sweet ☐ bitter ☐			
Is there any swelling or pain of your gums?			
Is there a history of gum disease in your family?			
Are you aware of sores/growths in your mouth?			
Do you notice any bleeding from your gums when you brush your teeth, or other?			
Have you had a local anaesthetic (freezing)?			
....any complications?			
Do you have burning sensation of lips or tongue?			
Does your mouth tend to get dry?			
Do you have bad taste in your mouth or bad breath?			
Are you nervous about having dental treatment?			
Have you ever had an upsetting experience in a Dental office?			
EXPLAIN :			

	No	NS	Yes
ORAL HYGIENE			
Do you use Dental aids?			
Do you use any fluoride/mouth rinse?			
Are you happy with the appearance of your teeth?			
What would you like to change about your teeth?			
How often do you brush your teeth?			
How often do you floss your teeth?			
JAW PROBLEMS Do you have any of the following?			
Clicking/popping of jaw when opening/closing?			
Pain (in jaw joints, ear, side of face)?			
Difficulty in opening or closing your mouth?			
Pain and/or difficulty in chewing?			
Pain when cleaning your teeth?			
Have you ever had implant surgery in one or both of your jaw joints?			
If yes, who performed the surgery and when was it done?			
Are you being followed-up by a dental specialist?			

HABITS Do you -	No	NS	Yes
Clench or grind you teeth while asleep?			
Bite your lips or cheeks regularly?			
Hold foreign objects with your teeth (such as pencils, pipe, pins, nails, and fingernails)?			
Breath through your mouth while awake or asleep?			
Snore when you asleep?			
Suck your thumb?			

TREATMENTS	No	NS	Yes
Orthodontic treatment (braces)			
Oral surgery?			
Periodontal treatment (gum surgery)?			
Teeth ground or bite adjusted?			
Worn a bite plate or other appliance?			
Dental implants?			

GENERAL CONSENT STATEMENT

I certify that I have read understood and accurately completed the personal, medical and dental histories, to the best of my knowledge, and have not knowingly omitted any information. This information has been reviewed with me, and I have had the chance to ask questions and to receive answers regarding any medical and dental histories. As may be required, I consent to my physician being contacted regarding any specific medical question. I authorize the dentist to perform necessary diagnostic procedures and treatment, including general or local anaesthetic, as required, to achieve the proper level of dental care. I understand that I am financially responsible to the dentist for the dental services provided even if my insurance coverage may not be all inclusive.

Patient ☐ **Parent** ☐ **Guardian** ☐ **Date :** _____ **Signature :** _____

I wish to pay each visit as services are performed ☐ Cash ☐ Cheque ☐ Interac ☐ Credit Card ☐ Other ☐

I wish to discuss special arrangement for payments ☐ *Interest of 2% per month on late payments will be charged automatically*

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ________________ Phone : ________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist ______________________________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________________________
____
List of medications (Prescription or Non-Prescription Drugs) currently used: 1. ______________ 2. ____________
3. ____________________ 4. ____________________ 5. ____________________ 6. ____________________

______________________________ Date :____________ Reviewed by :________________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______________ Date : ______________

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ________________ Phone : ________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist ______________________________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________________________
____
List of medications (Prescription or Non-Prescription Drugs) currently used: 1. ______________ 2. ____________
3. ____________________ 4. ____________________ 5. ____________________ 6. ____________________

______________________________ Date :____________ Reviewed by :________________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______________ Date : ______________

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ________________ Phone : ________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist ______________________________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________________________
____
List of medications (Prescription or Non-Prescription Drugs) currently used: 1. ______________ 2. ____________
3. ____________________ 4. ____________________ 5. ____________________ 6. ____________________

______________________________ Date :____________ Reviewed by :________________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______________ Date : ______________

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ________________ Phone : ________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist ______________________________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________________________
____
List of medications (Prescription or Non-Prescription Drugs) currently used: 1. ______________ 2. ____________
3. ____________________ 4. ____________________ 5. ____________________ 6. ____________________

______________________________ Date :____________ Reviewed by :________________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______________ Date : ______________

Have you changed your Family Physician? Yes ☐ No ☐ New Physician: ________________ Phone : ________
Are you under the care of a Medical Specialist? Yes ☐ No ☐ Specialist ______________________________
Are there any changes to your Health History? Yes ☐ No ☐ Please specify: ____________________________
____
List of medications (Prescription or Non-Prescription Drugs) currently used: 1. ______________ 2. ____________
3. ____________________ 4. ____________________ 5. ____________________ 6. ____________________

______________________________ Date :____________ Reviewed by :________________
Signature: Patient ☐ Parent ☐ Guardian ☐ Doctor's Initials: ______________ Date : ______________

Patient Privacy Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality 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, the Privacy Information Officer is:

Dr. Maria Gorospe

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.

In 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 protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body 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 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 below 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
- to communicate with other treating health-care providers, including specialists and referring doctors
- 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 claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies 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 governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to evaluate the 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 office'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) 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 _____ can collect, use and disclose personal information about
(Name of clinic or doctor)

_____ as set out above in the information about the office's privacy policies.
(Patient's name)

Signature _____ Print Name _____

Date _____ Signature of Witness _____