

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

**PATIENT INFO**

**FOR PATIENTS YOUNGER THAN 18 YEARS**

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_  
 Gender: Female / Male Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone/Other: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 How should we reach you for appointment reminders?  
 If phone, which number? \_\_\_\_\_  
 If email, which address? \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_  
 \_\_\_\_\_  
 Other family members seen by our practice: \_\_\_\_\_  
 \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Person present with patient at the exam: \_\_\_\_\_  
 Person(s) responsible for account: \_\_\_\_\_  
 Address (if different from the patient): \_\_\_\_\_  
 \_\_\_\_\_

	Mother	Father	Other
Name			
Home Phone			
Cell Phone			
History of orthodontic treatment?			

Do you have insurance that covers orthodontic treatment? Y / N  
 If so, please fill in the name of the insurance company?  
 \_\_\_\_\_

**DENTAL HISTORY**

**Dentist's Name:** \_\_\_\_\_  
 Last dental visit: \_\_\_\_\_  
 Frequency of dental visits: \_\_\_\_\_  
 Frequency of tooth brushing: \_\_\_\_\_  
 Frequency of flossing: \_\_\_\_\_  
 Do you have any missing/extra teeth? \_\_\_\_\_  
 Do you have any tooth/gum pain? \_\_\_\_\_  
 Do you have a strong gag reflex? \_\_\_\_\_  
 Have you had your tonsils/adenoids removed? \_\_\_\_\_  
 Have you ever been evaluated for orthodontic treatment? Y / N  
 If so, when? \_\_\_\_\_  
 Have you ever experienced pain in your jaw joint? (TMJ/TMD)  
 Y / N  
 Do you notice any popping/clicking in your jaws? Y / N  
 Do you grind or clench your teeth? Y / N  
 Do you experience frequent headaches? Y / N  
 Do you have neck/shoulder pain? Y / N  
 Have you ever had an injury to your :  
 a)mouth? B)teeth? C) chin / jaw?

Do you have any speech problems or speech therapy? Y / N  
 Do you generally breathe through your mouth? (mouth breathing)  
 Y / N  
 Do you have a tongue thrust? Y / N  
 Did you ever suck your thumb/finger? Y / N  
 Please explain any "Yes" responses to the above questions:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Do you like your smile?  
 \_\_\_\_\_  
 What do you want to change/improve with orthodontic  
 treatment?  
 \_\_\_\_\_  
 \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Your current state of health is: a) good b) fair c) poor

If poor, please

explain: \_\_\_\_\_

Do you use any tobacco products? Y / N If so, how much? \_\_\_\_\_

Has the patient begun puberty? Y / N

If female, has menstruation begun? \_\_\_\_\_

### Have you ever had any of the following diseases or medical conditions?

Y / N	Abnormal bleeding/Haemophilia	Y / N	Fainting/dizziness
Y / N	Alcohol/Drug abuse	Y / N	Glaucoma
Y / N	Anemia	Y / N	Growth problems
Y / N	Arthritis	Y / N	Heart Attack/ Stroke
Y / N	Artificial Bones/Joints/Valves	Y / N	Heart Murmur / Congenital heart defect
Y / N	Asthma	Y / N	Hepatitis/liver disease
Y / N	High blood pressure/hypertension	Y / N	Herpes/Fever blisters
Y / N	Blood transfusion	Y / N	HIV/ AIDS
Y / N	Bone disorders/ bone loss	Y / N	Hormone/ endocrine problems
Y / N	Cancer/Chemotherapy	Y / N	Kidney problems
Y / N	Colitis	Y / N	Lupus
Y / N	Congenital Heart Defect	Y / N	Nervous Disorders/ Seizures
Y / N	Diabetes	Y / N	Radiation Treatment
Y / N	Difficulty breathing	Y / N	Rheumatic fever
Y / N	Developmental disabilities	Y / N	Shingles
Y / N	Lung disease/ tuberculosis/ emphysema	Y / N	Sinus problems
Y / N	Endocrine problems	Other	_____
Y / N	Enilepsy		

Please list any medications currently being taken: \_\_\_\_\_

Are you allergic / sensitive to latex? \_\_\_\_\_

Please list any allergies that you may have: \_\_\_\_\_

*I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in medical/financial status. I understand that consultation with my dentist or physician may be required and consent to that communication if necessary.*

Patient / parent/ guardian signature \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Month

Day

Year

## PERSONAL INFORMATION PROTECTION AND ELECTRONIC DOCUMENTS ACT (PIPEDA)

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 provide this service to our patients.

All staff members that 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 use and protection of your information.

In this office, **Dr. Shari Borsuk** acts as the Privacy Information Officer.

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 me and 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.

- 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 (including the sharing of patient records such as x-rays, photographs, etc.) with other treating health-care providers, including specialists and general dentists who are 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 of 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 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 discloser 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 purpose of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA, and for the defense 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 the permission to release such information. We may advise you as well if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramification of that decision, and the process.

*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 Drs. Shari Borsuk and James Borovay can collect, use and disclose personal information about \_\_\_\_\_ as set out above in the information about the office's privacy policies. (Patients Name)*

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*Signature*

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*Print Name*

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*Date*

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*Signature of Witness*

## **New Canadian Anti-Spam Legislation: Your consent is required.**

New Canadian anti-spam legislation came into effect on July 1, 2014. Please take a moment to confirm your consent that Ottawa West Orthodontics may use your email address to send you appointment confirmations and other information relevant to you and your orthodontic treatment.

Please note: you may withdraw this consent at any future time.

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Patient Name

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Patient/ Parent/ Guardian signature

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Date