GranDview Dental Clinic

MEDICAL HISTORY

CONFIDENTIAL PATIENT INFORMATION

TODAYS DATE:_______________________________

Patient Name:__________________________________ **Birth Date(D/M/Y):**_______________________________
Address (Home):________________________________ **City:**______________ **Postal Code:**___________________
Home Ph:_______________________ **Cell Ph:**__________________ **Work Ph:**_______________________
Best time to call:__________________ **AM/PM**
Email:____

***IN CASE OF AN EMERGENCY*, WE SHOULD NOTIFY:**
Name:______________________ **Relation:**______________________ **Day-time Phone:**______________________
Name of family doctor:_____________________________ **Phone:**_________________________

HEALTH INFORMATION

Name of previous Dentist:_________________ **Date of last visit:**_____________ **Reason for this visit:**______________

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

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease/Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay fever
- ☐ Head Injuries
- ☐ Heart Disease/Infection
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Migraine Headaches
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumactic Fever
- ☐ Rheumatism
- ☐ Sinus problems
- ☐ Smoking
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Allergies:

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ Sulpha Allergy
- ☐ Other:____________________

IF FEMALE:

- ☐ Taking birth control?
- ☐ Currently Pregnant? If so number of weeks____________
- ☐ Currently nursing?

PLEASE LIST YOUR MEDICATIONS:
____
____
____
____
____
____

- Have you ever had a replacement or repair of a heart valve or heart transplant? ☐ No ☐ Yes
- Have you ever had any complications following dental treatment? ☐ No ☐ Yes Please Explain:______________________
- Have you been to a hospital or needed an emergency care during the past two Years? ☐ No ☐ Yes
  Please Explain:____
- Are you now under any care of a physician? ☐ No ☐ Yes Please Explain:____
  - Name of Physician:_________________ Phone:__________________
- Do you have any health problems the need further clarification?____
- What's most important to you in a new dental home?____
- Whom may we thank for referring you to our practice?____

DENTIST'S NOTES:

DENTIST SIGNATURE:_________________________________ **DATE**____________________________

SPECIAL CONCERNS

Are you nervous about dental treatment? ☐ **No** ☐ **Yes**________________________

Are you interested in NO2(Laughing gas) or Oral Sedation? ☐ **No** ☐ **Yes**________________________

Do you suffer from Oral sleep apnea/lack of sleep? ☐ **No** ☐ **Yes**________________________

Would you like information on tooth whitening? ☐ **No** ☐ **Yes**________________________

Would you like more information on braces/invisalign? ☐ **No** ☐ **Yes**________________________

Are you aware of night time tooth grinding? ☐ **No** ☐ **Yes**________________________

Do require a sports mouth guard? ☐ **No** ☐ **Yes**________________________

What kind of brush do you use? Manual Or Electric When do you brush? AM / PM

Do you floss?___________________ **How many times a day/week?**_________________________

INSURANCE HOLDERS INFORMATION

Primary Insurance Plans:

Name of Insured: ____ Is insured a patient? ☐ No ☐ Yes

Last First MI

Insured's Birth Date: (DAY / MONTH / YEAR) ______________________ID #_______________ Group #______________

Insured's Address (if different from patient's Address):

____

Street Apartment # City Province Postal Code

Insured's Employer Name:____

Patients' relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name:____

Secondary Insurance Plans:

Name of Insured: ____ Is insured a patient? ☐ No ☐ Yes

Last First MI

Insured's Birth Date: (DAY / MONTH / YEAR) ______________________ID #_______________ Group #______________

Insured's Address (if different from patient's Address):

____

Street Apartment # City Province Postal Code

Insured's Employer Name:____

Patients' relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name:____

Please initial all applicable items:

___I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.

___To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

FINANCIAL POLICIES

Your insurance benefits are between you, your employer, and your insurance company. We will do our best to work with your insurance company and submit claims on your behalf. Payment plans available on request.

All estimates for care approximate.

We require 2 business days' notice for appointment cancellations. A fee will be added to your next appointment in circumstances where sufficient notice is not given.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient:____ **Date:**__________________________

Printed Name of Patient:____

PAITENT CONSENT FORM:
COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal health information is an important part of our office providing, you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health 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. Swati Ajwani & Dr. Priya Ramachandran act as the Privacy Information Officers.

All staff members who come in contact with your personal health 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 health information complies with 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 PATIENT 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 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 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 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 is 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 agree that Dr. Swati Ajwani & Dr. Priya Ramachandran can collect, use and disclose personal information as set out above in the information about the office's privacy policies.

____

Signature

____

Print Name

____

Date