



## HEALTH INFORMATION

The following information is required by our clinical dental team to assist in proper diagnosis and treatment planning. All information is strictly confidential. Please check YES or NO to each question. If you are unsure of a question, please contact your dental provider.

- |                                                                                                                                                                                                                         | Yes                      | No                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Do you identify as a patient with a disability?<br>If yes, please explain: _____                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you being treated for any medical condition at present or within the past 2 years?<br>If yes, please explain: _____                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been hospitalized or had a serious illness in the last 2 years?<br>If yes, please explain: _____                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has there been any changes in your general health in the past year?<br>If yes, please explain: _____                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. When was your last medical check up? _____                                                                                                                                                                           |                          |                          |
| 6. Have you recently or are you presently taking any PRESCRIPTION or NON PRESCRIPTION drugs?<br>If yes, please list: _____                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever reacted adversely to any of the following? PLEASE CIRCLE<br>Antibiotics (e.g. Penicillin), Aspirin, Local Anaesthetic ("dental freezing"), Codeine, Nitrous Oxide ("laughing gas"),<br>or other: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have any of the following? PLEASE CIRCLE: Asthma, Hay Fever, Food Allergies, Metal or latex Allergies, Skin<br>rashes, hives, or any other allergic condition? _____                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do any of these allergic conditions result in head ache, nausea, swelling, shortness of breath or chest constriction?<br>If yes, please explain: _____                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you had any injury to or surgery on your face or jaws?<br>If yes, please explain: _____                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you smoke, or use any other form of tobacco/cannabis/vape? _____<br>Are you presently using nicotine replacement therapy (patch, gum)? _____                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you alcohol, cannabis or drug dependent? _____                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Women only: Are you pregnant or is there a chance you may be?<br>If yes, what is the expected delivery date? _____<br>If no, are you taking birth control medication?<br>Are you breastfeeding?                     | <input type="checkbox"/> | <input type="checkbox"/> |

### INDICATE WHICH OF THE FOLLOWING YOU HAVE EXPERIENCED:

	Yes	No		Yes	No		Yes	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles, feet or hands	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight loss, fever, night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough, coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	Frequent vomiting, nausea	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems, bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Throat infections	<input type="checkbox"/>	<input type="checkbox"/>

### INDICATE WHICH OF THE FOLLOWING YOU HAVE OR EVER HAD:

	Yes	No		Yes	No		Yes	No
AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A,B or C	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints (hip, knee etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> High <input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Steroid therapy	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hypo/Hyperglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Tumours	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Adrenal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Contact lenses or eye glasses	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hyperthermia	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Mental/Nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	Family history of Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Family history of Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Head/neck injuries	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant/medical implant	<input type="checkbox"/>	<input type="checkbox"/>	Family history of tumours	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>			

Are there any conditions or diseases not listed above that you have or have had? Yes  No

If Yes, please list: \_\_\_\_\_

## DENTAL INFORMATION

- |                                                                                                                                                                                 | Yes                      | No                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you having any dental problems or discomfort with your mouth that needs immediate attention?<br><i>If yes, please explain:</i> _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. When was your last visit to the dentist? _____                                                                                                                               |                          |                          |
| 3. Have you been seeing a dentist regularly?                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever had a bad dental experience or complication?<br><i>If so, please explain:</i> _____                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you experience anxiety or nervousness during dental appointments? _____                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. When was the last time you had Dental x-rays taken? _____                                                                                                                    |                          |                          |
| 7. Do you need antibiotics before dental treatment?                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you had any of the following? <i>Please check those that apply:</i>                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Periodontal Treatment <input type="checkbox"/> Orthodontic Treatment <input type="checkbox"/> Night Guard/Bite Plate <input type="checkbox"/> Implants |                          |                          |
| <input type="checkbox"/> Full Dentures <input type="checkbox"/> Partial Dentures <input type="checkbox"/> Fixed Bridgework <input type="checkbox"/> Crowns                      |                          |                          |
| 9. Are there any growths or sore spots in your mouth?                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do your gums bleed when brushing/flossing or do you suffer pain or swelling of your gums?                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you noticed any of your teeth are loose or shifting?                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you lost any teeth or have you had any extractions?                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does food get caught between your teeth?                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Are any of your teeth sensitive to hot, cold, sweets or pressure?                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. How often do you brush your teeth? _____                                                                                                                                    |                          |                          |
| 16. Do you use any of the following? <i>Please check those that apply:</i>                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Dental Floss <input type="checkbox"/> Proxa brush <input type="checkbox"/> Stimudents <input type="checkbox"/> Mouthwash                               |                          |                          |
| <input type="checkbox"/> Rubbertip stimulator <input type="checkbox"/> Waterpik <input type="checkbox"/> Electric toothbrush <input type="checkbox"/> Tooth picks               |                          |                          |
| 17. Do you have or have you had an unpleasant taste or odour in your mouth?                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do you experience or have you experienced any of the following? <i>Please check those that apply.</i>                                                                       |                          |                          |
| <input type="checkbox"/> Popping, clicking/snapping or pain in your jaw during chewing                                                                                          |                          |                          |
| <input type="checkbox"/> Pain in or around your ears or side of the face                                                                                                        |                          |                          |
| <input type="checkbox"/> Difficulty opening or closing your mouth                                                                                                               |                          |                          |
| 19. Do you have any of the following habits? <i>Please check those that apply:</i>                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Clenching of teeth <input type="checkbox"/> Thumb sucking <input type="checkbox"/> Chewing on pencils/pens                                             |                          |                          |
| <input type="checkbox"/> Grinding of teeth <input type="checkbox"/> Mouth breathing <input type="checkbox"/> Chewing on fingernails/checks/tongue or lips                       |                          |                          |
| 20. Are you happy with the appearance of your smile?<br><i>If no, what would you like to change?</i> _____                                                                      | <input type="checkbox"/> | <input type="checkbox"/> |

## GENERAL RELEASE

I, the undersigned, certify that all the personal, dental and medical information provided in this document is true to the best of my knowledge, and I have not omitted any information. I have had the opportunity to ask questions and receive answers to my questions regarding my dental and medical history. Should there be any change in my health status in the future, I will advise the office. I authorize the clinical team to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand that the information provided from or to my medical doctor or another health care provider may be necessary, and I consent to the release of this information.

Authorized Signature: \_\_\_\_\_  Patient  Parent  Guardian      Date: \_\_\_\_\_

Name of Guardian: \_\_\_\_\_ Please Print

Dentist's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 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. Robert vanGalen acts as a 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.

Our office will collect, use and disclose information about you for the following purposes:

- to deliver safe and efficient patient care
- to identify and ensure continuous high quality service
- to assess your health needs
- 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 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 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 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 condition 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 specific consent. When unusual requests are received, we will contact you for your permission to release such information. We may also advise you if such a release is inappropriate. 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. In addition, information older than 24 months may be stored offsite in a secure location.

Please do not hesitate to discuss our policies with any member of our office staff.

### PATIENT CONSENT

I have reviewed the above information that explains how the office will use my personal information, and the steps the office is taking to protect my information. I know that the office has a Privacy Code, and I can ask to see the Code at any time.

I agree that Fifth Avenue Family Dental Centre can collect, use and disclose personal information about \_\_\_\_\_ as set out above in the information about the office's privacy policies.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

]Witness Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_