TORONTO DENTAL
SPECIALISTS

CONFIDENTIAL PATIENT RECORD

Patient Name: First _____ Last _____

Date of Birth: Day: _____ Mo: _____ Yr: _____ Gender: □ F □ M Medical Alert: _____

Address: _____ Postal Code: _____

Phone: (H) _____ (W) _____ (C) _____

Email Address: _____

Family Doctor: _____ Phone Number: _____

Whom may we think for referring you? _____

MEDICAL HISTORY

1. Are you currently in good health? □ Yes □ No If No, please explain _____

2. Are you presently under the care of a physician? □ Yes □ No If Yes, please explain _____

3. Are you currently taking any medications? □ Yes □ No Please list: _____

4. Are you allergic to or ever had a reaction to any of the following: (Please click all that apply)

□ Penicillin Sulfa drugs □ Local Anaesthetic (freezing) □ Latex

□ Codeine □ Aspirin (ASA) Other _____

5. Do you have any allergies? _____

6. Have you ever taken cortisone or steroid medications? E.g. Prednisone □ Yes □ No

7. Have you ever had chemotherapy or radiation therapy? □ Yes □ No

8. Do you smoke or chew tobacco? □ Yes □ No

9. Do you bleed longer than normal after a cut/surgery/previous tooth removal? □ Yes □ No

10. Have you been hospitalized in the last 2 years? □ Yes □ No

If yes please explain _____

11. Have you ever had a serious illness or operation? □ Yes □ No

12. Do you have or ever had any of the following conditions? (Please click all that apply)

□ Heart Trouble □ Joint Surgery □ Thyroid Disorder □ Breathing Problems □ Stroke □ Blood Disorders

□ HIV Positive □ Rheumatic Fever □ Heart Defect □ Kidney Disease □ Arthritis Hepatitis

□ Mental Illness □ High/Low Blood Pressure □ Diabetes □ Tumors or Cancer □ Epilepsy or Seizures

□ Liver Disease □ Hormonal Disorder □ Immune Deficiency □ Sexually Transmitted Disease (STD)

□ Asthma □ Multiple Sclerosis (MS) □ Tuberculosis Other _____

13. WOMEN: Are you pregnant? □ Yes □ No

14. Is there anything else we should know about your health? _____

_____

DENTAL HISTORY

1. What dental condition(s) concern you at present? _____

2. When was your last dental check up and cleaning appointment? _____

3. Have you had any complications or difficulty with previous dental treatment? □ Yes □ No

4. Are your teeth sensitive to: □ Hot □ Cold □ Sweet Other _____

5. Do your gums bleed when: □ Flossing □ Brushing □ Never

6. Do your gums feel swollen or tender? □ Yes □ No

7. Do you have bad breath or a bad taste in your mouth? □ Yes □ No

8. Are you interested in having teeth whitening? □ Yes □ No

9. Do you grind your teeth and have TMJ problems? □ Yes □ No

10. How do you describe yourself as a patient? □ Calm □ Slightly nervous □ Apprehensive

CONSENT FOR TREATMENT

I hereby certify that Medical and Dental Histories are accurate and complete to the best of my knowledge. I consent to the performing of the dental procedures agreed to be necessary or advisable, including the use of local anaesthetic or any drugs as indicated:

(Children under 16 years of age must have parents or guardian signature)

_____ _____

Date: (YYYY-MM-DD) Signature

ELECTRONIC SUBMISSIONS

I authorize release to my insuring company plan administrator the information contained in claims submitted electronically.

_____ _____

Date: (YYYY-MM-DD) Signature

Toronto Dental Specialists

PERSONAL INFORMATION CONSENT

Our office is dedicated to protecting your privacy in a professional and responsible manner. This form summarizes the personal information that we collect, use and disclose. In addition to the circumstances described in the form, we also collect, use and disclose personal information when permitted or required by law.

We retain personal information such as names, home addresses, home, work, and cell numbers. Other personal information we collect may include policy and ID numbers in order to process your claims, and includes financial information as well. This personal information is collected and used for the following purposes:

- To open and update patient files.
- To invoice patients for dental services, to process credit card payments or to collect unpaid account.
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination for treatment.
- To send patients informative materials about our practice.

Personal information may be disclosed to a third-party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement purposes or payment for all or part of the cost of dental treatment or has asked us to submit a claim on their behalf.

We collect information from our patients with regards to their medical history, family health history, physical condition and previous dental treatments. Patient's medical information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. We may disclose information to the following:

- Insurance companies where the patient has submitted a claim for reimbursement or payment of dental treatment or when we submit a claim on the patient' s behalf.
- Other dental providers and specialists, where we seek a second opinion with the patient's consent.
- Other dental providers and specialists, with patient' s consent for referral.
- Other health care professionals such as physicians, if the patient, with their consent, has been referred by us, for either a second opinion or treatment.

We treat your personal information with respect and care. For security purposes, only persons authorized by **Toronto Dental Specialists** can review this information. Throughout the year, we send correspondence by mail and email. If you prefer to opt out of our mailing system, please **call 416-221-2950** or email us at **smi1e@oralhealth4life.net.**

Due to privacy laws, we are legally bound to hold in confidence personal information of our clients who have reached the age of majority but are still listed as dependents with a parent/guardian. This includes clients who are listed as dependents with their parent(s) financially with or without insurance coverage. **Toronto Dental Specialists** assumes no responsibility of informing the parent/guardian of legal age within Ontario (18 years of age) of treatment provided, treatment deemed necessary and the cost of said treatment. This remains the sole responsibility of each client and their families.

I give **Toronto Dental Specialists** consent to retain, use and disclose my personal information as stated above.

Date: (YYYY-MM-DD)	Print Name	Signature

If signing on behalf of another individual, please note the name of the client below and the relationship you have with the patient.

Print Name of Client	Relationship to Client