ACQUAINTANCE INFORMATION

The data on this confidential form is essential if we are to render the best professional care. We appreciate your co-operation in filling it out carefully so that we will have accurate records. **Please print - Thank you.**

PERSONAL INFORMATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	HOME PHONE

HOME ADDRESS	CITY/TOWN	POSTAL CODE

DATE OF BIRTH M / D / Y	E-MAIL ADDRESS	OCCUPATION

EMPLOYER	BUSINESS PHONE

BUSINESS ADDRESS	BY WHOM WERE YOU REFERRED	MARITAL STATUS

NAME OF PARTNER	OCCUPATION	BUSINESS PHONE

WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT?	IN CASE OF EMERGENCY NOTIFY	PHONE #

INSURANCE INFORMATION/IF YOU HAVE A DENTAL PLAN PLEASE COMPLETE THE FOLLOWING

NAME OF INSURANCE COMPANY	IS PARTNER UNDER ANOTHER PLAN ☐ Yes ☐ No

IF COVERDED UNDER PARTNER'S PLAN AS SECONDARY COVERAGE, PLEASE PROVIDE COMPANY NAME

MEDICAL HISTORY

PHYSICIAN	ADDRESS	PHONE

Are you currently under medical treatment? If so, for what: ______

Have you had an allergic or unusual reaction to: **(Please circle your answer to each question. If yes, please explain.)**

Aspirin	Yes	No	______	Cosmetics	Yes	No	______
Codeine	Yes	No	______	Metals	Yes	No	______
Dental Anaesthetic	Yes	No	______	Other Medicines	Yes	No	______
Penicillin	Yes	No	______	Women: Are you pregnant?	Yes	No	Expected Date of Delivery ______

Have you ever been treated for any of the following:

AIDS/HIV	Yes	No	Glaucoma	Yes	No	Pain In The Chest	Yes	No
Anaemia	Yes	No	Hay Fever	Yes	No	Persistent Cough	Yes	No
Anorexia or Bulimia	Yes	No	Heart Attack	Yes	No	Rheumatic Fever	Yes	No
Arthritis	Yes	No	Heart Defects	Yes	No	Rheumatoid Arthritis	Yes	No
Asthma	Yes	No	Heart Murmurs	Yes	No	Shortness Of Breath	Yes	No
Bleeding Problems	Yes	No	Heart Trouble	Yes	No	Seizures	Yes	No
Blood Disorders/Problems	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Bowel Problems	Yes	No	Hepatitis A, B or C (Liver Disease)	Yes	No	Skin Disorder	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Stroke	Yes	No
Coughing Up Blood	Yes	No	Jaundice	Yes	No	Thyroid Problems	Yes	No
Diabetes	Yes	No	Kidney Problems	Yes	No	Tuberculosis	Yes	No
Drug or Alcohol Dependency	Yes	No	Leukemia	Yes	No	Ulcer	Yes	No
Emphysema	Yes	No	Liver Problems	Yes	No	Venereal Disease	Yes	No
Epilepsy	Yes	No	Lung Disease	Yes	No	Other		
Gastrointestinal Disorders	Yes	No	Lupus	Yes	No			
			Mitral Valve Prolapse	Yes	No			

If yes, please give details:

1. Have you ever been hospitalized or had a serious illness or had any surgery? .... Yes No ______
2. Are you or have you received any psychiatric care and are you receiving medication for this? .... Yes No ______
3. Are you being treated for any condition by a physician? .... Yes No ______
   A. presently? Yes ☐ No ☐ ______
   B. in the last 2 years Yes ☐ No ☐ ______
4. Have you taken any drugs, pills, medicines or tablets in the last 2 years up to and including the present? .... Yes No ______
5. Do you ever have asthma, hayfever, hives, skin rash? .... Yes No ______
6. Have you ever had an adverse reaction to any drug including local anaesthetic (freezing) or general anaesthetic? Yes No ______
7. Are you allergic to latex? .... Yes No ______
8. Do you have any other allergies? .... Yes No ______
9. Have you had any unexplained weight loss, increasing thirst or appetite or increase in frequency of urination? Yes No ______
10. Have you ever taken cortisone? .... Yes No ______
11. Do you bleed for a prolonged period of time when cut? .... Yes No ______
12. Do you have any problems with healing when cut or bruised? .... Yes No ______
13. Is there any history of disease in your family? .... Yes No ______
14. Have you ever fainted? .... Yes No ______
15. Is there anything that the dentist should know about your medical history that has not been mentioned? ..... Yes No ______
16. Are you pregnant or nursing? .... Yes No ______
17. Are you presently taking any drugs or medicines? (please circle) .... Yes No

Antibiotics or sulfa drugs	Drugs for heart trouble	Sedatives or sleeping pills
Anticoagulants (blood thinners)	High blood pressure medicine	Tranquilizers
Antidepressants	Insulin, Diabinese or similar drug	Water pills
Cortisone	Nitroglycerin	Other ______

11/25/2015 WED 14:49 【JOB NO. 6657】 ☑001

18. Have you had any joint replacements? .... Yes No ______

19. Have you ever or are you now receiving radiation therapy or chemotherapy? .... Yes No ______

20. Do you have any in-dwelling catheters? .... Yes No ______

21. Have you ever taken appetite supressant drugs, for example fenfluramine, phenteramine or dexfenfluramine? Yes No ______

22. Do you smoke? If so, how much. ______ Yes No

23. Do you have a pacemaker? .... Yes No

24. Have we missed anything? ______

Patient's Signature ______ Medical history taken by ______ Date ______

DENTAL HISTORY

PREVIOUS DENTIST	ADDRESS	DATE OF LAST VISIT	PHONE

1. When was your last dental visit? ______
2. How often do you have a dental check-up? ______
3. Have you ever had an unfavourable experience at the dentist? .... Yes No ______
4. Do you have any discomfort in your teeth due to hot, cold, sweets, biting or chewing pressure? .... Yes No ______
5. Does food catch between your teeth? ______ If so, where? ______
6. Do your gums bleed when brushing or flossing? .... Yes No ______
7. Are you conscious of bad breath or bad taste in your mouth? .... Yes No ______
8. Do you favour one side when chewing? .... Yes No ______
9. Are you unhappy with the appearance of your teeth, bite or smile? .... Yes No ______
10. If you could, would you change anything about your smile? .... Yes No ______
11. Do you consider your teeth beyond repair? .... Yes No ______
12. Do you ever wake up with a headache or have a tired feeling in your face or jaws? .... Yes No ______
13. Do your jaw joints pop, click or grate when opening widely? .... Yes No ______
14. Do you clench or grind your teeth? .... Yes No ______
15. Have you lost any teeth due to abscess, accident, decay or gum disease? (please circle) .... Yes No ______
16. Was tooth replacement suggested? .... Yes No ______

Please review your medical history on the other side. Indicate whether there is any change in your medical status, or if you are taking any new medications. Please indicate any changes below, with date and your signature.

1. ______
DATE ______ SIGNATURE ______

2. ______
DATE ______ SIGNATURE ______

3. ______
DATE ______ SIGNATURE ______

4. ______
DATE ______ SIGNATURE ______

5. ______
DATE ______ SIGNATURE ______

6. ______
DATE ______ SIGNATURE ______

7. ______
DATE ______ SIGNATURE ______

8. ______
DATE ______ SIGNATURE ______

9. ______
DATE ______ SIGNATURE ______

10. ______
DATE ______ SIGNATURE ______

11. ______
DATE ______ SIGNATURE ______

12. ______
DATE ______ SIGNATURE ______

13. ______
DATE ______ SIGNATURE ______

14. ______
DATE ______ SIGNATURE ______

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED CONSENT TO THE PERFORMING OF DENTAL AND ORAL SURGERY PROCEDURES AGREED TO BE NECESSARY OR ADVISABLE INCLUDING THE USE OF LOCAL ANAESTHETIC AND/OR RELATIVE ANALGESIA AS INDICATED, AND I WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THOSE PROCEDURES.

______ PATIENT'S (PARENT'S, GUARDIAN'S) SIGNATURE

______ DATE

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CURITY DENTAL CARE
Dr. Earl M. Magder, D.D.S.
947 O'Connor Drive
Toronto, ON M4B 2S7
416.755.0151

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. Earl M. Magder acts as the 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.

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 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

11/25/2015 WED 14:49 [JOB NO. 6657] ☑003

- 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/undcrtakings 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 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 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 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 Dr. Earl M. Magder can collect, use and disclose personal information about

______________________________ as set out above in the information about the office's privacy policies.

____
signature

____
print name

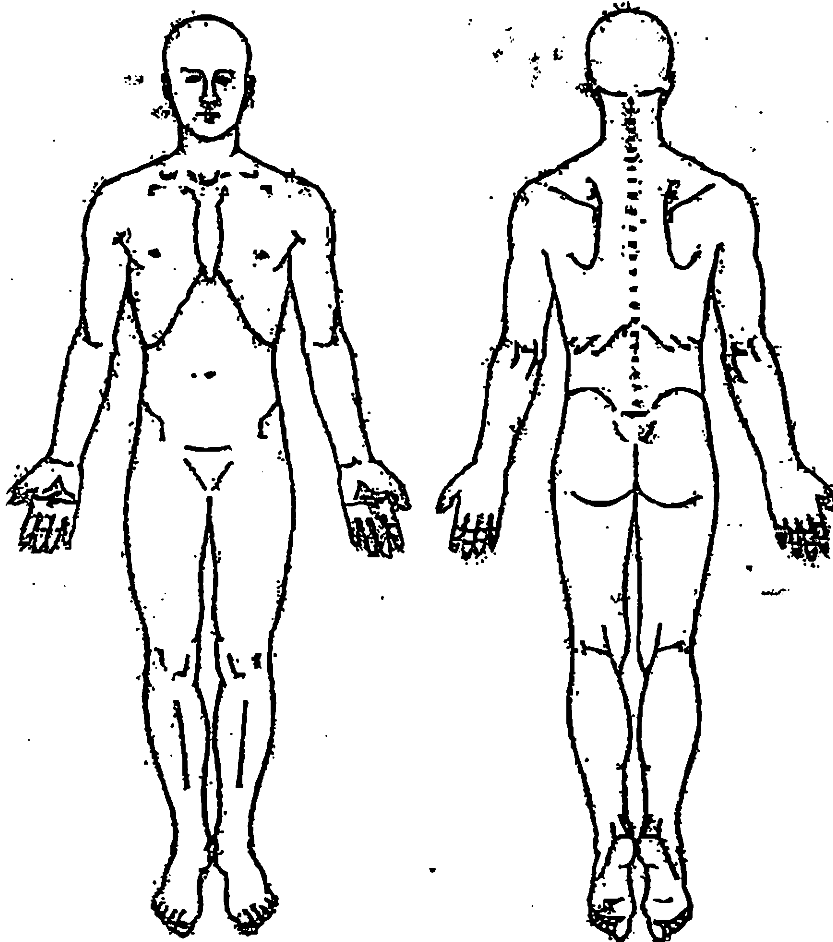
____
date

____
signature of witness

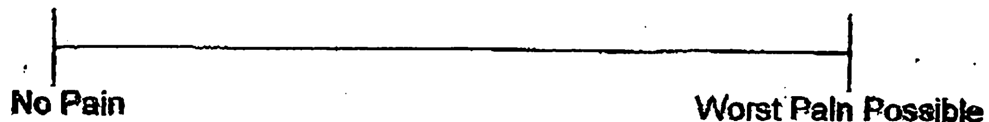
Body Diagram

Instructions:

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition.



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.



No Pain

Worst Pain Possible