

MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

POSTAL CODE:

PHONE:

EMAIL:

EMPLOYER:

WHO REFERRED YOU TO OUR OFFICE?

INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY:
POLICY #
ID/CERTIFICATION #

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST

AREA OF SPECIALITY:

PHONE:

(2) NAME OF MEDICAL SPECIALIST

AREA OF SPECIALITY:

PHONE:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why? YES NO NOT SURE/MAYBE

2. When was your last medical checkup?
3. Has there been any change in your general health in the past year? If yes, please explain. YES NO NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list. YES NO NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:
 - a. medications
 - b. latex/rubber products
 - c. other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain. YES NO NOT SURE/MAYBE

7. Do you have or have you ever had asthma? YES NO NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? YES NO NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? YES NO NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? YES NO NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? YES NO NOT SURE/MAYBE



Smile Questionnaire

Dr. Lackpour, Dr. Kowsari

Please complete the questionnaire and return it to the front desk

1. On a scale of 1 to 5, how happy are you with your smile?

(Unhappy) 1 2 3 4 5 (Happy)

2. Are you happy with the way your teeth look when you smile? Yes No

• If no, please explain why. _____

3. Do you think that all of your teeth are in alignment? Yes No

• If no, please explain why. _____

4. Do you have gaps in your teeth that you're unhappy with? Yes No

• If yes, please explain why. _____

5. Are you happy with the way your teeth are shaped? Yes No

• If no, please explain why. _____

6. Are you happy with the colour of your teeth? Yes No

• If no, please explain why. _____

7. Are you happy with the freshness of your breath? Yes No

• If no, please explain why. _____

8. Are your teeth sensitive? Yes No

9. Do your gums bleed when brushing? Yes No

10. Do you have any previous dental work or fillings that you are no longer happy with their appearance? Yes

No

• If yes, please explain why. _____

11. What are you most happy about with your smile?

12. What would you most like to change about your smile?

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.

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 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 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 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 DLK Dental can collect, use and disclose personal information about the undersigned as set out above in the information about the office's privacy policies.

Signature

Print Name

Date

Signature of Witness