(For office use only)

I.D. #	
MEDICAL ALERT Y ☐ N ☐	

Date ________________

Your co-operation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our receptionist is available to assist you with the completion of this form. PLEASE PRINT.

REGISTRATION INFORMATION

The patient is an: Adult ☐ Child ☐ Adult under guardianship ☐ Name of Guardian: ________

Name: (last) (first) (initial) Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐

Address: (street) (apt.#) (city) (province) (postal code)

Reason for today's visit? Examination ☐ Emergency ☐ Other ☐ ________

Is there a dental problem you would like treated immediately? ________ Preferred appt. time? ________

Home Phone: ( ) ________ Driver's Lic. No. ________ S.I.N. ________

Bus. Phone: ( ) ________ Ext. ____ Employer: ________ May we call you at work? ☐

Cell Phone: ( ) ________ Pager No: ( ) ________ E-Mail address: ________

PERSONAL INFORMATION

Prefers to be called: ________ Occupation: ________

Date of Birth: M___D___Y___ Age: _____ Sex: _____ Marital Status: _____ Name of Spouse: ________

Are other family members patients at our office? Yes ☐ Names: ________

Whom may we thank for referring you? ________

MEDICAL PRIORITY

Family Physician: ________ Phone: ( ) ________

Medical Specialist: (if presently under care) ________ Phone: ( ) ________

In case of emergency, please contact: ________ Phone: ( ) ________

Nearest relative not living with you: ________ Phone: ( ) ________

FINANCIAL INFORMATION

Person responsible for account: Self ☐ Spouse ☐ Other ☐ **Please complete all information if different than above.**

Name: (last) (first) (initial) Phone: ( ) ________

Address: (street) (apt.#) (city) (province) (postal code)

Credit Card info: MC ☐ VISA ☐ Number: ________ Expiry Date: ________

Signature: ________ This signature authorizes payment of my account on the above credit card.

PRIMARY DENTAL INSURANCE (If information available) SECONDARY DENTAL INSURANCE

Primary					Secondary				
Subscriber's name:			D.O.B.		Subscriber's name:			D.O.B.	
Emp./Grp. policy holder:			Ins. yr. end		Emp./Grp. policy holder:			Ins. yr. end	
Ins. Co.			Tel.		Ins. Co.			Tel.	
Grp./Ind. policy No.		Cert. No.			Grp./Ind. policy No.		Cert. No.		
I.D./S.I.N.		Max. Coverage.			I.D./S.I.N.		Max. Coverage.		
% coverage: Basic	Maj. Rest.	Ortho.	Other	Other	% coverage: Basic	Maj. Rest.	Ortho.	Other	Other

METHOD OF PAYMENT (For office use only) **CASH** ☐ **CHEQUE** ☐ **CREDIT CARD** ☐ **OTHER** ☐

PATIENT REGISTRATION **DENTAL HISTORY**

DENTAL HISTORY

Please ✔ YES or NO to each question. If unsure of a question, please consult with the dentist.

Is there a dental problem you would like treated immediately? Yes ☐ No ☐ ____________

	YES	NO
Date of your last dental visit? ________ Last dental cleaning? ________ Last x-rays? ________		
1. Have you been seeing a dentist regularly? ________	☐	☐
2. Have you ever had any of the following?		
- Periodontal Treatment? (treatment of the gums) ________	☐	☐
- Orthodontic Treatment? (to straighten or realign teeth) ________	☐	☐
- A bite plate or any other appliance? ________	☐	☐
- Your bite adjusted or teeth ground? ________	☐	☐
- Oral surgery? (surgery in or about the mouth/jaw joint, or implant surgery in one or both of your jaw joints?)	☐	☐
If you answered "yes" to the last question, who performed the surgery? ________ When? ________		
Are you being followed up by a dental specialist? ________	☐	☐
3. Are there any growths or sore spots in your mouth? ________	☐	☐
4. Do your gums bleed when brushing or eating, or, do you suffer from pain or swelling of your gums? ________	☐	☐
5. Have you noticed any loose teeth, or, have any of your teeth shifted? ________	☐	☐
6. Does food catch between your teeth? ________	☐	☐
7. Are any of your teeth sensitive to heat, cold, sweets or pressure? ________	☐	☐
8. Have you been advised to take antibiotics before a dental appointment? ________	☐	☐
9. Do you use dental floss, proxabrush or stimudents? How often? ________	☐	☐
10. How often do you brush your teeth? ________ Do you feel that you have bad breath? ________	☐	☐
11. Have you ever experienced any of the following jaw problems:		
- Popping/clicking in your jaw joints? ________	☐	☐
- Pain in your jaw joints, around your ear, or side of your face? ________	☐	☐
- Difficulty in opening or closing? ________	☐	☐
- Pain when teeth are clenched? ________	☐	☐
- Pain or difficulty while chewing? ________	☐	☐
12. Do you have any of the following habits?		
- Clenching or grinding your teeth while awake or asleep? ________	☐	☐
- Biting your cheeks or lips? ________	☐	☐
- Mouth breathing while awake or asleep? ________	☐	☐
- Placing foreign objects in your mouth (pencils, nails, pipes, pins, fingernails)? ________	☐	☐
13. Do you have any emotional concerns about having dental treatment? ________	☐	☐
14. Are you unhappy with the appearance of your teeth? ________	☐	☐
and, What would you like to see changed? ________		
15. Have you ever had an upsetting experience in a dental office, or any complications during or following dental treatment, or, do you have any questions or concerns? ________	☐	☐

The dental hygiene services provided in connection with treatment at our facility are provided by Simon Dental Hygienist Services Inc.. This company is owned and operated by Dr. Mark Simon - the fees charged for services provided by Dr. Mark Simon and by Simon Dental Hygienist Services Inc. are in accordance with the guidelines of the Ontario Dental Association.

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical - dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in my health status in the future, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that 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. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

X ____________________ ____________________

(signature) Patient ☐ Parent ☐ Guardian ☐ (print name of guardian)

Reviewed by Treating Dentist: ____________________ Date: ____________

FORM: DMDSEL RMSPRDH
CUST SIMON REV:4

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Name:	D.O.B. M D Y	Patient/Parent/Guardian Initial:	Date: M D Y

Please ✓ YES or NO to each question. If unsure of a question, please consult with the dentist. **YES NO**

1. Are you being treated for any medical condition at present or within the past two years? If yes, please explain: ☐ ☐
   ________ Physician: ________ Phone: ________
2. Have you been hospitalized in the past two years? ________ ☐ ☐
3. When was your last visit to a Physician? ________ Last complete physical examination? ________
4. Have you recently, or are you presently, taking any **prescription** or **non-prescription** drugs incl. herbal remedies ☐ ☐
   1. ________ 2. ________ 3. ________
   4. ________ 5. ________ 6. ________
5. Have you ever reacted adversely to any medications or injections? (Please circle.) e.g.Penicillin, or otherantibiotics aspirin, codeine, local anaesthetic (freezing), nitrous oxide, or any other medicine: ________ ☐ ☐
6. Have you ever been advised against taking any specific type of medication? ________ ☐ ☐
7. Do you have any of the following? Asthma, Hay Fever, Food Allergies, Metal or Latex Allergies, Skin Rashes, Hives, or any other allergic conditions? ________ ☐ ☐
8. Do any of these allergic conditions result in headache, nausea, swelling, shortness of breath, or chest constriction? If so, please explain: ________ ☐ ☐
9. Is there a family history of Diabetes, Cancer or Heart Disease? ________ ☐ ☐
10. Do you bleed EXCESSIVELY from a cut or injury, or bruise easily? ________ ☐ ☐
11. Do your ankles, feet or hands swell? ________ ☐ ☐
12. Has your weight, appetite or energy level changed dramatically recently? ________ ☐ ☐
13. Do you follow a special diet, or are you on a diet pill therapy? ________ ☐ ☐
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ________ ☐ ☐
15. Have you tested HIV positive? ________ ☐ ☐
16. Do you have FREQUENT SEVERE headaches, earaches, ear/throat infections? ________ ☐ ☐
17. Have you ever had any injury or surgery to your face or jaws? ________ ☐ ☐
18. Do you wear eyeglasses or contact lenses? ________ ☐ ☐
19. Do you have any hearing difficulties? ________ ☐ ☐
20. Do you smoke or use any other forms of tobacco? ________ ☐ ☐
    Are you wearing the transdermal nicotine patch? ________ ☐ ☐
21. Are you alcohol and/or drug dependent? ________ ☐ ☐
    and, Have you received treatment? ________ ☐ ☐
22. INDICATE WHICH OF THE FOLLOWING YOU PRESENTLY HAVE OR EVER HAD:

	YES	NO		YES	NO		YES	NO
A.I.D.S.	☐	☐	Glaucoma	☐	☐	Lupus	☐	☐
Anemia	☐	☐	Head/neck injuries	☐	☐	Malignant Hyperthermia	☐	☐
Angina pectoris	☐	☐	Heart disease or attack	☐	☐	Mental/nervous disorder	☐	☐
Arthritis/rheumatism	☐	☐	Heart murmur	☐	☐	Mitral valve prolapse	☐	☐
Artificial heart valve	☐	☐	Heart pacemaker	☐	☐	Organ transplant/medical implant	☐	☐
Artificial joints(hip, knee)	☐	☐	Heart rhythm disorder	☐	☐	Psychiatric treatment	☐	☐
Blood disorders	☐	☐	Heart surgery	☐	☐	Radiation treatment/chemotherapy	☐	☐
Bronchitis	☐	☐	Hepatitis A B C ________	☐	☐	Scarlet fever ➤ Rheumatic fever	☐	☐
Cancer	☐	☐	Herpes	☐	☐	Sickle cell disease	☐	☐
Circulation problems	☐	☐	High/Low blood pressure	☐	☐	Sinus trouble	☐	☐
Congenital heart lesions	☐	☐	Hodgkins disease	☐	☐	Stomach/intestinal problems/Ulcers	☐	☐
Cortisone/steroid	☐	☐	Hyper (Hypo) Glycemia	☐	☐	Stroke	☐	☐
Crohn's disease	☐	☐	Hypertension	☐	☐	Thyroid disease	☐	☐
Diabetes	☐	☐	Inflammatory bowel disease	☐	☐	Tuberculosis	☐	☐
Emphysema	☐	☐	Jaundice	☐	☐	Venereal Disease	☐	☐
Epilepsy or seizures	☐	☐	Kidney disease	☐	☐	Other ________		
Fainting or dizzy spells	☐	☐	Liver disease	☐	☐	Other ________		
Glandular disorders	☐	☐	Lung disease	☐	☐	Other ________		

23. Has the CHILD PATIENT recently had any of the following: (indicate approximate date.)

	YES	NO		YES	NO
Measles ________	☐	☐	Strep throat ________	☐	☐
Mumps ________	☐	☐	Tonsillitis ________	☐	☐
Chicken Pox ________	☐	☐			

24. Do you currently have, or have you had in the past, any disease, condition or problem not listed above? ________ ☐ ☐
25. Is there anything else about your health we should be made aware of? ________ ☐ ☐
26. Do you wish to speak privately to the Doctor about any problem or medical condition? ________ ☐ ☐
27. **Women only:** Are you pregnant or suspect you may be? ______ Expected delivery date? ______ Are you breast feeding? ______
    Are you taking any birth control pills? ______ **Women over 50:** Are you aware of your bone mineral density? ______

MEDICAL HISTORY

MEDICAL HISTORY UPDATES

SIMON DENTAL CENTRE
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, Charlene Argiropoulos, Office Manager, 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.

In 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 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 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 Simon 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	Signature of witness