iSmile | ORTHODONTISTS

Dr. Greg S. Dugas BSc, DDS, MSc, D. ORTHO, FRCD(C)
65 Springbank Ave North Unit 1 Woodstock, ON. N4S 8V8
519.804.4169 | info@ismileorthodontists.ca
ismileorthodontists.ca

ORTHODONTIC PATIENT INFORMATION AND HEALTH HISTORY

Welcome to our office. Please fill out both sides of this form.

PLEASE TELL US ABOUT YOUR CHILD

Patient Name: _____ Age: Years_____ Months_____ Gender: _____ Grade: _____

Home Address: _____ Birth Date: (dd/mm/yyyy) _____

City: _____ Postal Code: _____ School: _____

Phone: (_____) _____ Mobile ❑ Business ❑ Home ❑ Parent 1 ❑ Parent 2 ❑

Email: _____ Parent 1 ❑ Parent 2 ❑

FAMILY HISTORY

	Parent 1	Parent 2
Name:	_____	_____
Address: (If same:❑)	_____	(If same:❑) _____
Phone:	(_____) _____	(_____) _____
	Mobile ❑ Business ❑ Home ❑	Mobile ❑ Business ❑ Home ❑
Place of Employment:	_____	_____

Patient Living With: Both Parents ❑ Parent 1 ❑ Parent 2 ❑ Other Provider ❑

Other Family Members Seen By Us: _____

Siblings (Name and Age): _____

PERSON RESPONSIBLE FOR FINANCIAL MATTERS Both Parents ❑ Parent 1 ❑ Parent 2 ❑ Other Provider ❑

Name: _____ Relationship to the Patient: _____

Home Address: _____ City: _____ Postal Code: _____

Phone: (_____) _____ Mobile ❑ Business ❑ Home ❑ Parent 1 ❑ Parent 2 ❑ Other Provider ❑

Email: _____

Place of Employment: _____

	Family Dentist	Family Physician	Referred By
Name:	_____	_____	_____
Address:	_____	_____	_____
City, Prov.:	_____	_____	_____

MEDICAL HISTORY (please circle any applicable items)

Y N Allergies: Latex ❑ Metal ❑
Y N Anemia
Y N Arthritis
Y N Artificial Joints/Valves
Y N Asthma/Difficulty Breathing
Y N Birth Defects/Congenital Defects
Y N Cancer
Y N Cold Sores
Y N Diabetes
Y N Endocrine Problems
Y N Emotional Problems
Y N Epilepsy/Seizures
Y N Headache/Migraine
Y N Heart Condition/Murmur
Y N Head or Face Injury
Y N Hemophilia/Bleeding Problems
Y N Hepatitis
Y N Herpes
Y N HIV Positive
Y N Kidney/Liver Disease
Y N Mitral Valve Prolapse
Y N Oral Ulceration
Y N Previous Surgery
Y N Rheumatic Fever
Y N Thyroid Problems
Y N Tuberculosis
Y N Other(Describe Below)

❑ NO TO ALL OF THE ABOVE

If "yes", please explain: _____

Has your child been under the care of a physician during the past 2 years (other than for routine examinations)? No ❑ Yes ❑

If "yes" please explain: _____

Does your child require pre-medication (antibiotics) for dental procedures? No ❑ Yes ❑

Please list any medications (including dosage/frequency) currently taken: _____

_____

_____

RESPIRATORY HISTORY Does your child:

1. Have allergies to: Latex: _____ Metal: _____ Medications: _____
   Food: _____ Seasonal: _____ Other: _____
2. Breathe through their mouth? Seldom ❑ Sometimes ❑ Always ❑ When? Daytime ❑ or Night-time ❑
3. Snore when sleeping? No ❑ Yes ❑
4. Have frequent colds? No ❑ Yes ❑
5. Have frequent "stuffy nose"? No ❑ Yes ❑
6. Have frequent sore throat or tonsillitis? No ❑ Yes ❑
7. Have chewing or swallowing difficulties? No ❑ Yes ❑
8. Has your child received medical treatment from an allergist or ear, nose, and throat (ENT) specialist? No ❑ Yes ❑
   If "yes" when: _____ By whom: _____
   Nasal Surgery (Date): _____ Tonsils Removed (Date): _____ Adenoids Removed (Date): _____

DENTAL AND TEMPOROMANDIBULAR JOINT HISTORY

Has your child had any unusual dental experiences? No ❑ Yes ❑

If "yes" please explain: _____

Date of last dental checkup: _____ Were the patient's teeth cleaned? No ❑ Yes ❑

Has your child ever been treated for TMJ (TMD or "Jaw Joint") problems? No ❑ Yes ❑

Does your child have:

1. Difficulty with mouth opening? No ❑ Yes ❑
2. Pain or clicking in the jaw joint? No ❑ Yes ❑
3. Pain on chewing, yawning, or opening wide? No ❑ Yes ❑
4. Pain in or about the ears or cheeks? No ❑ Yes ❑
5. A bite that feels "uncomfortable" or "unusual"? No ❑ Yes ❑
6. A jaw that "locks"; "gets stuck" or "goes out"? No ❑ Yes ❑
7. Noises in or from the jaw joint No ❑ Yes ❑

The following habits are of interest. List information as it pertains to your child:

1. Thumb-sucking ❑; Finger-sucking ❑; Lip-sucking ❑ until _____ (age) No ❑ Yes ❑
2. Grinding ❑ or Clenching ❑ of the teeth When? Daytime ❑ or Night-time ❑ No ❑ Yes ❑
3. Tongue thrusting or other functional problems No ❑ Yes ❑

Has your child had a previous orthodontic consultation? No ❑ Yes ❑ or previous orthodontic treatment? No ❑ Yes ❑

Date: _____ Dr. _____ City, Province: _____

If "yes" please explain: _____

_____

_____

Why do you seek this consultation (chief complaint)? _____

_____

_____

What is expected from orthodontic treatment? _____

_____

_____

Signature: _____ Date: _____

PATIENT CONSENT FORM:
FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

- The privacy of your personal information is an important part of our office providing you with quality orthodontic care. We understand the importance of protecting your personal information and 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. Greg Dugas BSc, DDS, MSc, D.ORTHO, FRCD(C)** acts as the Privacy Information Officer.
- All staff members who encounter 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 the 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 myself 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 highest quality orthodontic 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 accomplish this, we have outlined below how our office is using and disclosing your personal information.
- Specifically, this office will collect, use and disclose information about you for the following purposes:
    - To assess your health needs.
    - To provide health care.
    - To deliver safe and efficient patient care.
    - To identify and to ensure continuous high-quality service.
    - To advise you of treatment options.
    - To enable us to contact you and maintain communication with you to offer and provide treatment and services in relationship to the oral and maxillofacial complex and to communicate with other treating health-care providers, including specialists and general dentists involved with your care.
    - To enable us to contact you and maintain communication with you to distribute health-care information and to schedule and confirm appointments.
    - To enable us to contact you and maintain communication with you to allow for proper scheduling and appointment sequencing.
    - To enable us to contact you and maintain communication with you to efficiently follow-up for treatment, care and billing purposes.
    - 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 (RHPA).***

- 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 prepare materials for the Health Professions Appeal and Review Board (HPARB).
- To assist this office to comply with all regulatory requirements.
- To comply generally with the law.
- To permit potential purchasers, practice brokers or advisors to evaluate the orthodontic 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 invoice for goods and services.
- To process credit card payments.
- To collect unpaid accounts.

- 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 above. 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. If such a request is made, we will forward the information directly to you for your 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.
- At any time, you may withdraw your consent for use and/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 agree that **Dr. Greg Dugas BSc, DDS, MSc, D.ORTHO, FRCD(C)** 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