TECUMSEH
DENTAL CENTRE

Medical History Questionnaire

MEDICAL ALERT:

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

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

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

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 OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

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 currently being treated for any medical condition or have you been treated within the past year? If yes, please explain? ☐ 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 them.
   ☐ Yes ☐ No ☐ Not Sure/Maybe

5. Do you have any allergies? If yes, please list them using the categories below: ☐ Yes ☐ No ☐ Not Sure/Maybe

a) medications _____

b) latex/rubber products _____

c) other (e.g. hay fever, seasonal/environmental, 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

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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

12. Have you ever had hepatitis, jaundice or liver disease? ☐ Yes ☐ No ☐ Not Sure/Maybe

13. Do you have a bleeding problem or bleeding disorder? ☐ Yes ☐ No ☐ Not Sure/Maybe

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

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15. Do you have or have you ever had any of the following? Please check.

☐ chest pain, angina	☐ rheumatic fever	☐ pacemaker	☐ steroid therapy	☐ seizures (epilepsy)
☐ heart attack	☐ mitral valve prolapse	☐ lung disease	☐ diabetes	☐ kidney disease
☐ stroke, TIA	☐ tuberculosis	☐ stomach ulcers	☐ thyroid disease	☐ shortness of breath
☐ heart murmur	☐ cancer	☐ arthritis	☐ drug/alcohol/cannabis use or dependency	☐ osteoporosis medications (e.g. Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.
☐ Yes ☐ No ☐ Not Sure/Maybe

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17. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)?
☐ Yes ☐ No ☐ Not Sure/Maybe

18. Do you smoke or chew tobacco products? ☐ Yes ☐ No ☐ Not Sure/Maybe

19. Are you nervous during dental treatment? ☐ Yes ☐ No ☐ Not Sure/Maybe

20. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
☐ Yes ☐ No ☐ Not Sure/Maybe

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21. Do you identify as a patient with a disability? If yes, please explain. ☐ Yes ☐ No ☐ Not Sure/Maybe

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To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature: _____ Date: _____

DENTIST'S NOTES:

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120 - 11811 Tecumseh Rd E, Tecumseh ON N8N 4M7 519-735-5555 smile@tecumsehdental.com www.TecumsehDental.com

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Dental History Questionnaire

Name:_____

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. What is the reason for your visit today? Are you currently experiencing any dental problems?

_____

2. Have you been seeing a dentist regularly? If not, why not?

_____

3. When was your last dental visit? What was done at that appointment?

_____

4. When did you last have dental x-rays?

_____

5. How often do you brush your teeth? How often do you floss? Do your gums bleed?

_____

6. Are you nervous about dental visits? YES NO NOT SURE
7. Have you ever had a bad experiences during dental treatment? YES NO NOT SURE
8. Have you ever seen a dental specialist? YES NO NOT SURE
9. Have you been told to take antibiotics before dental appointments? YES NO NOT SURE
10. Do you feel that you have bad breath? YES NO NOT SURE
11. Are you happy with the appearance of your teeth? YES NO NOT SURE
12. Do you have any problems with your jaw (Pain, difficulty opening)? YES NO NOT SURE
13. Have you ever had an injury to your teeth or jaws or been involved in a motor vehicle accident?

_____ YES NO NOT SURE

To the best of my knowledge the above information is correct:

Patient/Parent/Guardian Signature: Date:

Dentist's Signature: Date:

Dentist's Notes:

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TECUMSEH
DENTAL CENTRE

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

The privacy and protection of your personal information is a top priority at Tecumseh Dental Centre. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly. We intend to be as open and transparent as possible about the way we handle your personal information.

In this dental office, Dr. Jennifer Kerr acts as the privacy information officer. All staff members who require access to 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. Our information collection policy maintains that:

- Only necessary information is collected about you.
- We only share your information with your consent.
- Storage, retention, and proper destruction of your personal information complies with the 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.

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 access your health needs.
- To provide health needs.
- To advise you of treatment options.
- To establish and maintain communication with you.
- To enable us to contact 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 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 on your behalf to third party insurance companies for the purpose of adjudication and payment processing.
- To complete and submit dental predeterminations/estimates on your behalf to third party insurance companies in order to assist you with financial planning for recommended treatment.
- 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 voluntary by the member with the 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 should occur.
- To prepare materials for the Health Professions Appeal and Review Board (HPARB)
- To invoice for goods and services.
- To process credit card, cash and personal cheque payments.
- To collect unpaid accounts.
- To assist this office to comply with all regulatory requirements.
- To comply generally with the law.
- To report suspected abuse in the case of a minor under legal and dental regulation mandates to authorities that are legally authorized to receive this information.

By signing the consent section of this patient consent form, you 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 if 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 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 your permission to release the necessary information. We may also advise you if such a release is inappropriate.

You have the right to withdraw your consent for the use and/or disclosure of your personal information at any time, and we will explain the ramifications of that decision, and the process.

Please do not hesitate to ask any further questions of our office at any time. We are happy to help and our goal is for you to receive the highest form of dental care.

More information about the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Protection Act (PHIPA) can be found at **priv.gc.ca**

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 personal and confidential information. I agree that **Dr. Jennifer Kerr and Associates** can collect, use and disclose my personal information as set above in the information about the office's privacy policies in accordance with PIPEDA/PHIPA regulations.

Signature: _____

Date: _____

Print Name:_____

Signature of Witness:_____

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Our office is pleased to offer direct billing to your dental insurance company should your policy allow for direct assignment of payments.

Insurance benefits are designed to offset the cost of your dental needs, however having insurance is not a guarantee of coverage. Actual benefits will be determined based on eligibility and plan limitations such as fee guide rules, co-payments, deductibles, and yearly maximums. In some cases, your insurance company may choose to deny payment for a benefit that is approved on your plan based on their own internal rules.

Our treatment recommendations will always be based on your individual needs, NOT on what your insurance company covers. We will make every reasonable effort to help you understand your policy and coverage so that you make an informed choice, but ultimately you are responsible for any portion that is not covered by your plan once you consent to the recommended procedures and associated fees.

Failure to pay your portion in a timely manner or failure to help us resolve any insurance disputes related to your treatment will result in a loss of direct assignment privileges meaning all fees will need to be paid in full by you at the time of service, with the insurance company reimbursing you directly.

I, _____have read and understand the above policy. I agree to pay all balances that are not covered by my insurance.

_____
Sign Full Name.

_____
Date

_____
Witness (Office Staff)

DR. JENNIFER KERR PROSFFESIONAL DENTISTRY CORPORATION
O/A TECUMSEH DENTAL CENTRE