PERSONAL INFORMATION

Date of Birth: _____/_____/____

D M Y

Mr. ___ Mrs. ___ Miss. ___ Dr. ___ Other ___

Name: ____

First Middle Initial Last

Address____

(Number) (Street) (Appartment/Unit)

____

(City) (Province) (Postal Code)

Telephone: (H) ___________ (B) _________ Ext._____ Cell: __________

Email Address: ____

Referred by: ____

In case of emergency please notify: Name: ______________________

Relationship: ___________ Telephone: __________________

Family Physician: _______________ Telephone: _________________

Address: ____

Medical Specialist: ______________ Telephone: _________________

Address: ____

____

Name of insurance/insurer

Name of insured

Date of birth of insured

Group/Policy number

Division/Certification

Occupation

Place of business

2nd carrier with same information as above

Client name_______________________________________

(2) MEDICAL HISTORY

The following information is required by the dental hygienist to assist in proper assessment and treatment. All information is confidential.

1. Are you presently under the care of a physician? Yes_____ No_____
2. Have you ever been Hospitalized? Yes_____ No_____

   Specify:____
3. Do you have a heart or circulatory problem of any kind? Yes_____ No_____

   Specify:____
4. Do you have any allergies? Medications__________________ Latex/Rubber______________

   Foods____________________ Hay Fever____________________ Dyes__________________
5. Are you presently taking any medication? Yes _____ No_____

   Specify: A) Drug: ______________________________

   Reason: ______________________________

   B)Drug: ______________________________

   Reason: ______________________________

   C)Drug: ______________________________

   Reason: ______________________________

   D)Drug: ______________________________

   Reason: ______________________________

   Specify and Naturopathic or Holistic products used:

   ____

   ____

   Do you have a drug or alcohol dependency? Yes _____ No_____
6. Do you have a bleeding problem? Yes_____ No_____
7. Have you ever had a reaction to any kind of medication? Yes_____ No_____
8. Do you presently have or have you ever had:

   Anemia ___
   Arthritis ___
   Asthma ___
   Blood Disorder ___
   Cancer ___
   Diabetes ___
   Epilepsy ___
   Hay Fever ___
   Herpes ___
   Heart Disease ___
   Heart Murmur/Mitral Valve Prolapse ___
   Hemorrhage ___
   HIV+ Blood ___
   High Blood Pressure ___
   Low Blood Pressure ___
   Hyperglycemia ___
   Hypoglycemia ___
   Kidney Disease ___
   Joint Replacement ___
   Liver Disease ___
   Lung Disease ___
   Mental/Nervous Disorder ___
   Migraine Headache ___
   Rheumatism ___
   Rheumatic Fever ___
   Scarlet Fever ___
   Stomach (Intestinal Ulcer) ___
   Stroke ___
   Thyroid Condition ___
   Tuberculosis ___
   Venereal Disease/Sexually Transmitted Disease ___

9. Have you ever fainted? Yes_____ No_____
10. Have you ever had any illness not listed above? Yes_____ No_____
11. For women:
    Are you pregnant? Yes_____ No_____
    Delivery Date:____________________
12. Are there any diseases or medical problems that run in your family?
    Please specify:____

Date:__________ Blood Pressure:__________ Pulse:__________

(3) Dental History Dentist name____________________________________

1. How frequently do you see your dentist/dental hygienist?
   3 months_____ 6 months_____ Yearly_____ Other_____
2. Have you ever been given oral instructions in:
   Brushing_____ Flossing_____ Other_____
3. Have you ever had local anesthetic? Yes_____ No_____
   Any complications: Yes_____ No_____
   Explain:__________________________________
4. Are your teeth sensitive to:
   Cold_____ Hot_____ Sweets_____ Other_____
5. Do your gums feel tender and swollen? Yes_____ No_____
6. Do your gums bleed when:
   Brushing_____ Flossing_____ Spontaneously_____
7. Do you catch food between your teeth? Yes_____ No_____
8. Are you aware of any loose teeth? Yes_____ No_____
9. Have you ever had a full mouth series of x-rays or a panelipse? Yes_____ No_____
10. Does your jaw crack, pop, or grate when you open widely? Yes_____ No_____
11. Do you grind and /or clench your teeth? Yes_____ No_____
12. Have you had any facial surgery or jaw surgery? Yes_____ No_____
13. Have you had any implant surgery? Yes_____ No_____
14. Is there anything about the appearance of your teeth that you would like to change? Yes_____ No_____
    Explain:____
15. Chief Complaint/Concern____

CLIENT CERTIFICATION AND APPROVAL:

I, the undersigned, certify that all of the above medical and dental information is true to the best of my knowledge and I have not omitted any pertinent information.

Patient Signature:____________________________ Date:__________

Parental Signature/Power of Attorney:____________________________ Date:__________

CLIENT CONSENT:

I, the undersigned, consent to the performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

Patient Signature:____________________________ Date:__________

Parental Signature/Power of Attorney:____________________________ Date:__________

Privacy Code for Choice Independent Dental Hygiene

Privacy of personal information is important to Choice Independent Dental Hygiene. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be as open and transparent as to how we handle personal information.

PERSONAL INFORMATION

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, emergency contact, gender and age. As part of your patient file we retain your health and dental history; health conditions, dental and health assessments. Services provided to you or received by you, and the prognosis and other opinions formed; compliance with treatment; and the reasons for any referrals including your physician and dentist name and phone numbers. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and destruction of your personal information complies with the privacy legislation. Please update us if there is any changes in your information.

STAFF MEMBERS

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic administration and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

DISCLOSURE OF PERSONAL INFORMATION

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below our office disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To comply with legal and regulatory requirements

- To process payments and collect unpaid accounts

By signing the consent section of this 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.

AFTER YOUR VISIT

Occasionally, we may need to contact you with regards to treatment and/or scheduling. New privacy laws require that we obtain your permission before contacting you. Please check which numbers we may reach you at and whether we may leave a message.

Home Phone ☐ Leave Message: ☐ Yes ☐ No

Business Phone ☐ Leave Message: ☐ Yes ☐ No

Cell Phone ☐ Leave Message: ☐ Yes ☐ No

Please do not call me: ☐

Do you want to be included in future e-mails regarding events and information?

☐ Yes ☐ No

E-Mail________________________________

PATIENT CONSENT

I have reviewed the above information that explains how our office will use my personal information. I know that Choice Independent Dental Hygiene has a Privacy Code and I may ask to see it at any time.

I agree that Choice Independent Dental Hygiene can collect, use and disclose my personal information as set out above in the Offices Privacy Code.

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Print Name Signature

Date ________________________________