DENTAL HISTORY

★ Approximate date of last dental checkup? _____

★ Have you ever had any of the following:

- ☐ 1. Fillings
- ☐ 2. Regular cleanings
- ☐ 3. Recent dental X-rays
- ☐ 4. Nitrous oxide (laughing gas)
- ☐ 5. Periodontics (gum treatment)
- ☐ 6. Caps or crowns
- ☐ 7. Extractions
- ☐ 8. Root canal treatment
- ☐ 9. Full or partial dentures
- ☐ 10. Orthodontics (braces)
- ☐ 11. An injury to your mouth or jaws

	Yes	No
★ Have you ever had a local anaesthetic?	☐	☐
If yes, any problems? _____		
★ Have you ever had an 'unfavourable' dental experience?	☐	☐
If yes, explain _____		
★ Would you be interested in having nitrous oxide (laughing gas) during appointments?	☐	☐
★ Do you get 'cold sores' or 'mouth ulcers'?	☐	☐
If yes, how often? _____		
★ Would you like to improve the general cosmetic appearance of your teeth?	☐	☐
What would you like to change? _____		
★ Would you like to maintain and keep your natural teeth for a lifetime?	☐	☐

★ Do you presently have or think you may have any of the following:

- ☐ 1. Loose teeth
- ☐ 2. Cavities
- ☐ 3. Gum disease
- ☐ 4. Sensitive teeth
- ☐ 5. Bleeding gums
- ☐ 6. A bad taste in your mouth
- ☐ 7. A clicking or sore jaw
- ☐ 8. Earaches or headaches
- ☐ 9. Unsightly or broken fillings
- ☐ 10. Dead or abcessed teeth

★ In your own words, describe your present dental problem or needs: _____

_____

OFFICE PHILOSOPHY AND POLICY: (please read)

★ In an effort to determine a treatment plan that is best for your overall dental health, we must make a careful diagnosis. This involves a thorough examination, often utilizing the minimum number of X-rays necessary for accuracy.

★ We pledge to provide high quality dentistry in the most comfortable manner possible, with the best equipment, materials and up to date techniques.

★ The longterm success of our efforts will depend on the patients' willingness to maintain their teeth and prevent any future dental problems.

★ Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require 48 hours notice.

★ Our office policy is that services are paid for at each visit as they are performed. In certain circumstances, financial arrangements for payment may be made by consulting the doctor or receptionist.

★ **Regarding Insurance:** All patients with dental insurance are responsible for payment of their own accounts. We are pleased that you have insurance to reimburse or minimize your personal expenditure and we will gladly complete any claim forms to assist you in collecting your dental benefits. Please make certain you understand any limitations in your contract. We will gladly submit 'estimate' forms, if necessary.

★ All **urgent** dental problems will be attended to the same day, under normal circumstances. You may call our office or answering service at any time.

★ A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel relaxed and open to discuss with us, any aspect of your treatment or fees, at any time.

CONSENT FOR TREATMENT

This is to certify that I consent to the performing of the dental procedures agreed to be necessary and I will assume responsibility for fees associated with those procedures.

_____ _____

Date Signature (Parent or Guardian)

QUESTIONNAIRE UPDATE

1. Date _____ Notes _____
2. Date _____ Notes _____
3. Date _____ Notes _____
4. Date _____ Notes _____

★★ We are pleased to welcome you to our practice, and hope to provide you, your friends and relatives with the highest quality of dental care.

In order to render the best professional care it is necessary that we become acquainted with the vital information related to each patient. Of course all information is strictly confidential. We appreciate your cooperation in filling out this form carefully and accurately. (PLEASE PRINT, Thank you.)

			Date
Patient's Last Name	Mr. Mrs. Dr. Ms.	Given Names	Home Phone
Apt. Address		City	Postal Code
Date of Birth month day year – –	Social Insurance Number – –		Reason for today's visit ☐ Examination ☐ Emergency
Occupation	Employer		Business Phone
In case of emergency notify		Relationship	Phone
Name of person responsible for your account ☐ Self, Other:		Whom may we thank for referring you? Name:	
Do you have Dental Insurance?	Name of Insured Employee	Insurance Company	Employer
	Group Policy Number	Certificate or I.D. Number	
Policy Holder Date of Birth			
Family Physician	Phone	Previous Dentist	Address or Phone

MEDICAL HISTORY

	Yes	No
★ Is your physician currently treating you for any reason?	☐	☐
★ If yes, explain _____		
★ Have you ever been hospitalized?	☐	☐
If yes, specify _____		
★ Have you ever had a general anaesthetic?	☐	☐
Any problems? _____		
★ Do you bruise easily or bleed excessively when cut?	☐	☐
★ Are you currently taking any pills, drugs or other medicines?	☐	☐
If yes, please list: 1. _____ 2. _____		
3. _____ 4. _____		
★ Have you ever taken cortisone, steroids, anti-depressants, blood thinners, or thyroid medicine?	☐	☐
★ Do you smoke tobacco products?	☐	☐
★ Women, are you pregnant? If yes, when do you expect? _____		

★ Do you have any or have you ever had any of the following?

- ☐ 1. Heart disease or chest pains
- ☐ 2. High blood pressure
- ☐ 3. Heart murmur
- ☐ 4. Pacemaker or artificial valves
- ☐ 5. Rheumatic fever
- ☐ 6. Diabetes
- ☐ 7. Blood disorders or anemia
- ☐ 8. Lung or breathing problems
- ☐ 9. Asthma
- ☐ 10. Kidney or liver problems
- ☐ 11. Hepatitis
- ☐ 12. Thyroid problems
- ☐ 13. Stomach or intestinal problems
- ☐ 14. Tuberculosis
- ☐ 15. Arthritis
- ☐ 16. Artificial joint replacements
- ☐ 17. Epilepsy or seizures
- ☐ 18. Syphilis, gonorrhea, AIDS
- ☐ 19. Tumours or cancer
- ☐ 20. Radiation therapy
- ☐ 21. Shortness of breath

Please specify: _____

_____

★ Is there anything else concerning your health the doctor should know? _____

_____

★ Are you allergic to any medications or drugs?	☐	☐
If yes, explain _____		
★ Do you have any other allergies?	☐	☐
If yes, to what? _____		

Dr. Aviv Ouanounou
1017 Wilson Avenue, Suite 203
North York, Ontario M3K 1Z1
Telephone 416-633-5721

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, Dr. A. Ouanounou 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.

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 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 Patient 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 Dr. A. Ouanounou 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