RESTORATION™ ORTHODONTICS

For your benefit, please have this form completed and bring it with you to your first visit.

NAME: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____

POSTAL CODE: _____ HOME PHONE #: _____

CELL PHONE #: _____ WORK #: _____

* EMAIL ADDRESS: _____

☐ Male ☐ Female INSURANCE: ☐ Yes ☐ No ☐ Dual

REFERRED BY: _____ DENTIST: _____

Is any family member a patient at our office? ☐ No ☐ Yes: _____

Reason for seeking treatment: _____

MEDICAL HISTORY: Medical Doctor: _____

Please check any of the following conditions which apply to you:

☐ Severe Headaches	☐ Sore Throat	☐ Bleeding Gums	☐ Joint Pain
☐ Heart Disease	☐ Convulsions	☐ High Blood Pressure	☐ Poor Vision
☐ Fainting Spells	☐ Chest Pains	☐ Ease of Bruising	☐ Sinus Condition
☐ Ulcers	☐ Tooth Ache	☐ Dizzy Spells	☐ Shortness of Breath

Please check any of the following illnesses you have ever had:

☐ Rheumatic Fever	☐ Asthma	☐ Angina	☐ Psychiatric Care
☐ Hepatitis A,B or C	☐ TB	☐ Heart Disease	☐ Autism Spectrum
☐ Jaundice	☐ Scarlet Fever	☐ Thyroid Problem	☐ Emotional Disturbances
☐ Diabetes	☐ Mononucleosis	☐ Malignant Hyperthermia	☐ Learning Difficulties
☐ Anxiety/Depression	☐ HIV/Aids	☐ ADD/ADHD	☐ Herpes Virus (cold sores)

Are you suffering from any illness? _____

Please note any previous hospitalizations and surgeries, and the year: _____

_____

List any allergies to medicine or food: _____

List present medication: _____

How would you describe your health? _____

Is there anything in your medical history of which the dentist should be aware of, such as dental apprehension, fainting spells, low blood sugar or low blood pressure etc. _____

(Women:) Are you pregnant now? _____

DENTAL HISTORY:

1. When was your last check up and cleaning? _____
2. Is there any outstanding dental work that is still required? _____
3. Have you ever sought an orthodontic consultation or had orthodontic treatment previously? _____
4. Do you have difficulty chewing? _____
5. Are you conscious of any pain in your jaw muscle? _____

DATE: _____ **SIGNATURE**: _____

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. Mark Parete 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 personal information is collected and we only share this 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, efficient patient care and to identify and to ensure continuous high quality service
- to assess your health needs, provide health care and to advise you of treatment options
- to enable us to contact you and to establish and maintain communication
- 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 and 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 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 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. Voth & Dr. Parete (Parete Tolmie Dentistry PC) 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