Smith Family Orthodontics

Adult Patient Registration Form

529 Palace Road, Unit 1, Kingston ON K7L 4T6
Tel: (613) 544-4445 • Fax: (613) 544-4028

Welcome to our office. Please assist us by completing the following information regarding the patient and their medical and dental history. It is important that you answer all the questions as accurately as possible. Your answers to these questions are for our records only and will be kept strictly confidential, in compliance with privacy legislation, standards of our regulatory body, the Royal College of Dentists of Ontario, and the law.

Patient's name: Mr. /Mrs. / Ms. / Dr. _____
Last First

Date of Birth: _____ Age: _____ Sex: ❑ Male ❑ Female
Month Day Year

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell: _____

Email(s): _____

Name of other family members treated by our office: _____

How did you hear about our office? _____

Dentist's name: _____ Physician's name: _____

Medical History

1. Is the patient in good general health? ❑ Yes ❑ No
2. Is the patient under the care of a physician for any medical concern? ❑ Yes ❑ No
3. Is the patient taking any medications or drugs at the present time? ❑ Yes ❑ No
4. Has the patient ever had any serious illness, operation, or been hospitalized? ❑ Yes ❑ No
5. Does the patient have or ever had any of the following?

❑ asthma	❑ blood disorders	❑ joint replacement	❑ liver disease	❑ ulcers/stomach problems	❑ steroid therapy
❑ lung disease	❑ anemia	❑ heart attack	❑ hepatitis	❑ epilepsy or seizures	❑ AIDS or HIV
❑ allergies	❑ rheumatic fever	❑ stroke	❑ jaundice	❑ cancer	❑ diabetes
❑ hay fever	❑ heart murmur	❑ high/low blood pressure	❑ kidney disease	❑ arthritis/rheumatism	❑ thyroid disease
❑ sinus problems	❑ congenital heart defect		❑ gastrointestinal problems	❑ immune disorders	

6. Has the patient ever experienced any unusual reactions to any of the following?

❑ aspirin	❑ local anesthetics	❑ sulfonamides
❑ codeine	❑ other antibiotics	❑ latex
❑ penicillin	❑ nickel or other metal	❑ other: _____

7. For female patients: Is there a chance you may be pregnant? ❑ Yes ❑ No
8. Has the patient ever had any medical radiation therapy? ❑ Yes ❑ No
9. Is there anything that the orthodontist should know regarding the medical history of the patient that has not been mentioned? ❑ Yes ❑ No
10. Has the patient had their tonsils or adenoids removed? ❑ Yes ❑ No
11. Has the patient ever had a severe accident involving their teeth or jaws? ❑ Yes ❑ No

Dental and Orthodontic History

1. Is the patient concerned about the appearance of their teeth? ❑ Yes ❑ No
2. Is the patient aware or concerned about their orthodontic problem? ❑ Yes ❑ No
3. Is the patient interested in having their orthodontic problem treated? ❑ Yes ❑ No
4. Has the patient ever been teased about the appearance of their teeth? ❑ Yes ❑ No
5. Does the patient have any difficulty chewing or swallowing? ❑ Yes ❑ No
6. Does the patient suffer from any jaw joint problems? ❑ Yes ❑ No
7. Is there a history in your family of irregular teeth? ❑ Yes ❑ No
8. Is there a history in your family of protruding teeth? ❑ Yes ❑ No
9. Is there a history in your family of congenitally missing teeth? ❑ Yes ❑ No
10. Is there a history of trauma to the teeth or jaws? ❑ Yes ❑ No
11. Does any other family member have similar appearance of their jaws? ❑ Yes ❑ No
12. Does any other family member have a similar arrangement of teeth? ❑ Yes ❑ No
13. Does the patient breath through their mouth? ❑ Yes ❑ No
14. Does the patient play any wind instruments? ❑ Yes ❑ No
15. Does the patient have or ever had habits like thumbsucking, lipsucking, lip biting, or other habits? ❑ Yes ❑ No
16. Has the patient had a sudden increase in height? ❑ Yes ❑ No
17. Has the patient seen an orthodontist previously? ❑ Yes ❑ No
18. Has the patient had any previous orthodontic treatment? ❑ Yes ❑ No
19. Has any other member of the family had orthodontic treatment? ❑ Yes ❑ No
20. Briefly describe the main concerns the patient has with their teeth and/or jaws?

_____

_____

_____

_____

_____

_____

_____

Note: In order to avoid complications as a result of changes in the patient's medical condition it is important to notify our office of these changes during the course of orthodontic treatment.

For completion by the orthodontist

Medical History Update

Date	Comments	Initial

Smith Family Orthodontics Patient Consent Form

CONSENT 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. Darryl V. Smith 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 regulator 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 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 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 communications 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 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 Professional 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 chart and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials of 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 Profession Act (RHPA) for the purpose 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 Smith Family Orthodontics 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 _____