WELCOME TO OUR OFFICE!

PATIENT INFORMATION

Name: _____ Gender: M / F D.O.B: _____ /____ /____
Last First Initial YYYY/ MM / DD

Address: _____ Home Phone: _____
Street City Postal Code

Referred by:_____ List any sports, hobbies or interests:_____

Do you have orthodontic insurance coverage? ☐ Yes ☐ No

Policy Holder Name:_____ Employer: _____
_____

FAMILY INFORMATION

Mother's Name: _____
Last First Initial

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married ☐ Other

Home Address: _____ Home Phone: _____
(if different from above) Street City Postal Code

Work Phone: _____ Cell Phone: _____ Email: _____

How do you prefer to be contacted? (circle all that apply): Home Work Cell Email

Father's Name: _____
Last First Initial

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Re-married ☐ Other

Home Address: _____ Home Phone: _____
(if different from above) Street City Postal Code

Work Phone: _____ Cell Phone: _____ Email: _____

How do you prefer to be contacted? (circle all that apply): Home Work Cell Email

Person(s) responsible for payments on account: ☐ Mother ☐ Father ☐ Other
Name of Other Party: _____

Name and age of siblings (of patient): _____
_____

Medical History

Patient's Family Physician: _____ Phone #: _____

Yes	No	
☐	☐	Is your child under a physician's care at present? Describe: _____
☐	☐	Is your child being treated for any medical conditions? Describe: _____
☐	☐	Is your child currently taking any prescription or non-prescription medications? _____
☐	☐	Is your child allergic to any medications (e.g. Penicillin, sulfa drugs, pain relievers)? or Latex?_____
☐	☐	Has your child ever had any serious illness? Describe: _____
☐	☐	Has your child ever been hospitalized or undergone any type of surgery? Describe: _____
☐	☐	Has your child ever had prolonged bleeding following a tooth extraction or minor injury? _____
☐	☐	Are there any conditions or diseases that run in your family (e.g. diabetes, heart disease, cancer)? _____

☐ ☐ Does your child smoke or use any other tobacco products? If yes, how much? _____
☐ ☐ For females: is your child pregnant, or suspect that they may be?

Does your child have or ever had any of the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Rheumatic Fever	☐	☐	HIV/ AIDS	☐	☐	Tuberculosis (TB)
☐	☐	Seizures/ Epilepsy	☐	☐	Heart Murmur	☐	☐	Sinus Problems
☐	☐	Diabetes	☐	☐	Asthma	☐	☐	Allergies
☐	☐	Ear, nose or throat problems	☐	☐	Arthritis	☐	☐	Cancer/ Radiation therapy
☐	☐	Prosthetic Joint/ Valve	☐	☐	Thyroid Disease	☐	☐	Hepatitis or jaundice
☐	☐	Heart attack/ Stroke	☐	☐	Kidney Disorder	☐	☐	Malignant Hyperthermia
☐	☐	Heart Valve Disease	☐	☐	High/Low Blood Pressure	☐	☐	Bone Disorders
☐	☐	Blood disorder	☐	☐	Infectious Disease	☐	☐	Mental Health Problems
☐	☐	Persistent Headaches/Migranes	☐	☐	Sleep Apnea	☐	☐	Other_____

If you responded yes to any of the above, please give pertinent details: _____
_____
_____

Is there any other medical conditions the doctor should be aware of:_____
_____

_____

Dental History

Main reason you are seeking orthodontic treatment:_____
_____
_____

Patient's Dentist: _____ Date of last Exam: _____
How often does your child: visit the dentist?_____ brush?_____ floss?_____

Yes	No	
☐	☐	Is your child currently experiencing any dental pain? _____
☐	☐	Have you been informed of any missing or extra permanent teeth?
☐	☐	Has your child had any permanent teeth removed, including wisdom teeth? How many? _____
☐	☐	Has your child ever had previous orthodontic treatment or consultation? If yes, when? _____ Doctor? _____
☐	☐	Any injuries to the face, teeth, or mouth? Describe: _____
☐	☐	Do any untreated cavities exist?
☐	☐	Is there currently or any history of jaw or facial muscle pain?
☐	☐	Is there currently or any history of pain in your child's jaw joints? If yes, when? _____
☐	☐	Is there currently or any history of difficulty in your child opening or closing their jaws?
☐	☐	Does your child clench or grind their teeth?
☐	☐	Do you find that your child breathes predominantly through the mouth, or with their mouth open?
☐	☐	Has your child ever sucked their thumb or finger? If yes, until what age?_____
☐	☐	Does your child want orthodontic treatment?

Are there any other oral conditions that the doctor should be aware of?_____
_____

I have read and understand the above questions and the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is ***my responsibility to inform this office of any changes in medical/dental status****.*

_____
Signature of parent or guardian Date

_____
Reviewed by Dr. Greg Tolmie DDS, MSc, FRCD(C) Date
Dr. Caroline Cheung DDS, MSc, FRCD(C)

CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of information is an important part of how our office provides high-quality care. We understand the importance of protecting your information. We are committed to collecting, using and disclosing it responsibly. We also try to be as open and transparent as possible about the way we handle your information.

In this office, Dr. Greg Tolmie acts as the Privacy Information Officer.

All staff members who come in contact with your personal information have been trained in the appropriate uses and protection of your information. They are aware of its' sensitive nature.

Our goals are to ensure that:
We only collect necessary information and we only share 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 and the standards of our regulatory body, the RCDSO, and the law

How we collect, use and disclose patients' personal Information
This office will collect, use and disclose information about you for the following purposes:
to assess your health needs, advise you of treatment options and to deliver safe, effective, efficient patient care
to identify and to ensure continuous high quality service
to establish and maintain communication with you and to book and confirm appointments
to communicate with your general dentist and your other health-care providers, including dental specialists and physicians
to allow us to efficiently follow-up for treatment, care and billing
to provide the efficiency of our computerized check-in process your name must be displayed
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 permit potential purchasers, brokers, accountants or advisors to evaluate our practice.
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 process credit card payments, direct bank account debits and to invoice for services.
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.

Our office has a privacy code; copies of this code are available on request.

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 Tolmie Orthodontics can collect, use and disclose personal information about _____
as set out above in the information about privacy policies. (patient name)

_____ _____
signature print name

_____ _____
date signature of witness