EAST RIDGE FAMILY DENTAL

Patient Medical/Dental History Form - Child

Name: _____ _____ _____
Last Name Initial First Name

Address: _____

City: _____ Province: _____ Postal Code: _____

Home: ( ) _____Cell: ( ) _____Work: ( ) _____

Date of Birth (DD/MM/YY):_____/_____/_____ Email: _____

Person Responsible for Child's Account: _____ Relation to Child: _____

Emergency Contact: _____ Emergency Phone: ( ) _____

How did you hear about us?: _____ Health Card #: _____

Appointment Confirmations: ___ SMS/TEXT or ___ EMAIL

Insurance Coverage: Do you have dental insurance? Y N *If Yes complete the following ….*

Primary Insurance Coverage:

Policy Holder Name: _____ Ins Company: _____

Policy/Plan/Group #: _____ Certificate/I.D.#:_____

Policy Holder's Date of Birth:(DD/MM/YY):_____/_____/_____ Relation to Holder: _____

Secondary Insurance Coverage:

Policy Holder Name: _____ Ins Company: _____

Policy/Plan/Group #: _____ Certificate/I.D.#:_____

Policy Holder's Date of Birth:(DD/MM/YY):_____/_____/_____ Relation to Holder: _____

Health History:

Family Physician's Name: Dr. _____ Phone#: ( ) _____

Has there been any change in your child's general health? ..... Y N

If YES please describe: _____

Is your child being treated for any medical condition or have they been treated within the past 2 years? ..... Y N

If YES please describe: _____

Is your child currently being treated by a physician for a specific condition? ..... Y N

If YES please describe: _____

Is your child currently taking any medication? ..... Y N

If YES please list medication and dosage:

Name of Medication/Condition	*Dose*

Does your child bleed or bruise easily? ..... Y N

Has your child ever been hospitalized? ..... Y N

If YES please describe: _____

Has your child ever received general anesthesia? ..... Y N

Has your child ever had an adverse reaction to local anesthetic? ..... Y N

Does your child have any allergies to medications? ..... Y N

If YES please describe: _____

Does your child have any other allergies? ..... Y N

If YES please describe: _____

Does your child currently have any of the following conditions? *(Please circle)*

AIDS/HIV	Cancer	Heart Attack	Jaundice	Osteoporosis	Stroke
Arthritis	Diabetes -T1 / T2	Heart Murmur	Kidney Disease	Radiation Therapy	Thyroid Disease
Artificial Joint Replacement	Drug/Alcohol Abuse	Hepatitis A/B/C/D	Liver Disease	Rheumatic Fever	
Asthma	Epilepsy	High Blood Pressure	Mental Illness	Steroid Therapy	

Is there anything else the doctor needs to know regarding your child's medical health? ..... Y N

If YES please describe: _____

Dental History:

Has your child ever been to the dentist before? ..... Y N

If YES what age: _____

Is your child currently experiencing any pain or discomfort? ..... Y N

Are any of their teeth sensitive to: _____ Cold? _____ Hot? _____Sweet? _____Biting?

If YES, which teeth or areas: _____

Does your child have difficulty chewing food or does food get stuck between their teeth? ..... Y N

Has your child ever had braces for straightening their teeth? ..... Y N

Has your child ever had an injury to their jaw or face? ..... Y N

Has your child been examined by an ORTHODONTIST regarding growth patterns and development? ..... Y N

Patient Certification and Consent:

I, the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anesthetics or other prescribed drugs as indicated. I authorize the dentist to treat me and I assume full responsibility for the fees associated with these procedures.

Patient Consent: I have reviewed the information provided explaining how the office will use my personal information and the steps the office will take to protect my private information. I know that the office has a privacy policy and I can request to review it at any time. I am aware that the office will not sell my private information to a third party. I authorize the office to contact other health professionals, if necessary, on behalf of my family and myself.

Insurance Consent: I authorize the office to electronic sharing of information with my insurance company for processing insurance claims and determining benefit coverage. Unless other arrangements have been made, assignment of benefits from your insurance company will be set up. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and my dentist.

Appointment Policy: Broken appointments (e.g. short notice cancellations or no shows) are a disappointment to everyone; It can interfere with treatment progress and creates scheduling issues for future treatment. We strive to accommodate the needs of all our patients by providing the best possible dentistry, treatment options, and service available. We accomplish this by scheduling each patient in an especially reserved time specifically for your treatment. When an appointment time is agreed upon, we feel a commitment to the scheduled time and treatment has been made. I am aware that 2 business days' notice is required to change or cancel an appointment without charge. This allows us to manage and respect our doctors and hygienists time accordingly. We understand, in rare circumstances, that emergencies occur, and these will be assessed individually. Our goal is to communicate to you, our valued patients, and our policy regarding broken appointments to avoid this from occurring.

Electronic Communication Consent: I hereby consent to receive electronic communications from the office including appointment confirmation and reminders, newsletters, marketing material, account updates, treatment consents, post-operative instructions, promotions, and opportunities to provide feedback. I understand that I can withdraw my consent to receive electronic communications at any time by contacting the office. Please note that it is the patients responsible to update the office with any email address and/or cell phone number changes.

_____ _____

PARENT OR GUARDIAN SIGNATURE DATE

_____ _____

DENTIST'S SIGNATURE DATE

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. Hesham Sherghin 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 CLINIC COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION
Our clinic 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 clinic 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 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 the office will use my personal information, and the steps your clinic 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 the office can collect, use and disclose personal Information.

_____ _____

PATIENT, PARENT OR GUARDIAN SIGNATURE DATE