MEDICAL HISTORY QUESTIONNAIRE

MEDICAL ALERT:

NAME: MR./MISS/MRS./MS./DR.

DATE OF BIRTH (DAY/MONTH/YEAR): / /

ADDRESS (HOME):

PHONE:

ADDRESS (BUSINESS):

PHONE:

OCCUPATION:

WHO REFERRED YOU TO OUR OFFICE?

IN CASE OF EMERGENCY, WE SHOULD NOTIFY:

NAME:

RELATIONSHIP:

DAY-TIME PHONE:

NAME OF FAMILY DOCTOR:

PHONE OR ADDRESS:

(1) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

(2) NAME OF MEDICAL SPECIALIST:

AREA OF SPECIALITY:

PHONE OR ADDRESS:

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you being treated for any medical condition at the present or have you been treated within the past year? If so, why?

❑ YES ❑ NO ❑ NOT SURE/MAYBE

2. When was your last medical checkup?

3. Has there been any change in your general health in the past year? If yes, please explain.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

4. Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

5. Do you have any allergies? If you answered yes, please list using the categories below:

❑ YES ❑ NO ❑ NOT SURE/MAYBE

a) medications
b) latex/rubber products
c) other (e.g. hayfever, foods)

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

❑ YES ❑ NO ❑ NOT SURE/MAYBE

7. Do you have or have you ever had asthma? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

8. Do you have or have you ever had any heart or blood pressure problems? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

9. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

10. Do you have a prosthetic or artificial joint? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

12. Have you ever had hepatitis, jaundice or liver disease? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

13. Do you have a bleeding problem or bleeding disorder? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

14. Have you ever been hospitalized for any illnesses or operations? If yes, please explain. ❑ YES ❑ NO ❑ NOT SURE/MAYBE

15. Do you have or have you ever had any of the following? Please check.

- ❑ chest pain, angina
- ❑ heart attack
- ❑ stroke
- ❑ shortness of breath
- ❑ rheumatic fever
- ❑ mitral valve prolapse
- ❑ heart murmur
- ❑ pacemaker
- ❑ lung disease
- ❑ tuberculosis
- ❑ cancer
- ❑ steroid therapy
- ❑ diabetes
- ❑ stomach ulcers
- ❑ arthritis
- ❑ seizures (epilepsy)
- ❑ kidney disease
- ❑ thyroid disease
- ❑ drug/alcohol dependency
- ❑ osteoporosis medications (e.g. Fosamax, Actonel)

16. Are there any conditions or diseases not listed above that you have or have had? If so, what? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

17. Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer or heart disease) ❑ YES ❑ NO ❑ NOT SURE/MAYBE

18. Do you smoke or chew tobacco products? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

19. Are you nervous during dental treatment? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

20. For women only: Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? ❑ YES ❑ NO ❑ NOT SURE/MAYBE

To the best of my knowledge, the above information is correct:

PATIENT/PARENT/GUARDIAN SIGNATURE: **DATE:**

DENTIST SIGNATURE: **DATE:**

DENTIST'S NOTES

Chapman Mills **Dental**

Patient Consent for the Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our office in 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 responsibility. 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. John Fayad and Roxanne Stants act as the Privacy Information Officers. All staff members who come into 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.

Our office will ensure the following:

* 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, and the law.

Do not hesitate to discuss our policies with any member of our office staff. 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 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 request 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 agree that Chapman Mills Dental can collect, use and disclose personal information about me or my family as set out above in the information about the office's privacy policies.

Print Name :
Signature :
Date :
Signature of Witness :

Chapman Mills **Dental**

EMAIL CONSENT FORM

Patient's Name _____

Responsible Party_____

Email Address_____

By providing your e-mail address, you are agreeing for Chapman Mills Dental to email appointment reminders promotional offers or any occasional e-mails.

If, at any time, you would like to unsubscribe to appointment reminders or any other e-mails received through our website, please contact our office 613-823-4001 to be removed.

I, _____, consent to receiving e-mails
Patient/Parent/Guardian

from Chapman Mills Dental.

Date:_____

Signature_____
Patient/Parent/Guardian

Patient Consent Form

Medical Information

Your information is private and confidential and will remain so in our clinic. Your medical information will not be shared with anyone unless you give us prior consent.

Consultation Report

As is standard practice in our medical profession, a consultation report will be forwarded to your referring doctor and dentist. Information that you provide in this document may be shared with them. If you do not want a report to be sent, please let us know during your initial visit.

Financial Policy

We are a fee-for-service practice. Therefore, we appreciate receiving full payment when services are rendered. All fees will be discussed with you before beginning any treatments.

Insurance

Our front desk will gladly help fill out all of your insurance forms in order for you to claim payments from your insurance company.

Consent to Photograph for Patient Care and Medical Record Purposes

Photographs may be taken during your first visit to assist in the diagnosis and treatment rendered.

Appointment Cancellation Policy

We strive to proved consistent quality patient care. Once an appointment is made, we ask that you keep it. If you cannot, we require 48 hours notice for cancellations.

Your signature below indicates that you have read and understood the above information

_____	_____
Name	Date of Birth
_____	_____
Signature	Date

Chapman Mills **Dental**

EDI Signature

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

_____ _____

Signature of patient, parent or guardian Date

Chapman Mills **Dental**

CANCELLATION POLICY

Your appointment time is reserved especially for you.
If you cancel within less than 2 business days of your scheduled appointment, we not only lose your business, but also the potential business of other clients who could have taken your scheduled appointment time. For this reason we are still obligated to compensate staff for their time as well as make up for our lost revenue. We kindly ask that you give us 2 BUSINESS DAYS to cancel or reschedule your appointment. Appointments cancelled in less than the required time will be billed $50.00.

Please sign and date that you've read and agree to the above cancellation policy.

Date: _____

Signature: _____