MEDICAL ALERT

Date: _____

PATIENT INFORMATION

PIPEDA COMPLIANT FORM

Name: _____ Mrs. □ Ms. □ Miss. □ Mr. □ Dr. □
(last) (first) (initial)

Home Address: _____
(street) (city) (province) (postal code)

Home Phone: _____ Business Phone: _____ Cellphone: _____

Date of Birth: _____ Age: _____ Sex: _____ Parent/Guardian (if appl): _____

Occupation: _____ Employer: _____

May we call you at work? Yes □ No □ Email: _____

Family Physician: _____ Phone: _____

Medical Specialist (if presently under care):_____ Phone: _____

DENTAL INSURANCE: Yes □ No □

Primary Insurance Co. Name: _____ Grp. Pol. #: _____ Certif. #: _____

Secondary Insurance Co. Name: _____ Grp. Pol. #: _____ Certif. #: _____

PERSON RESPONSIBLE FOR ACCOUNT: Self □ Other □ ➡ Name: _____

Address: _____

Home Phone: _____ Business Phone: _____

IN CASE OF EMERGENCY: Notify: _____ Relationship: _____

Home Phone: _____ Business Phone: _____

Who may we thank for referring you to our office? _____

MEDICAL HISTORY Please check YES or NO. If not sure, check NS.	YES	NO	NS	
Are you being treated for any medical condition at present or within the past year?				
When was your last medical check-up? _____				
Has there been any change in your general health in the past year? If yes, please explain below:				
Are you taking any medications, non-prescription drugs, or herbal supplements? If so, please list:				
Do you have any allergies to medications, foods, or substances? If so, please list below:				
Do you have or have you ever had heart or heart or blood pressure problems?				
Do you have or have you ever had an artificial heart valve, an infection of the heart (ie. infective endocarditis), a heart condition from birth (ie. congenital heart disease), or a heart transplant?				
Do you have or have you ever had jaundice, hepatitis or liver disease?				
Do you have any conditions or therapies that could affect your immune system (eg. AIDS, HIV positive, leukemia, radiotherapy, chemotherapy, etc)?				
Do you have a bruising problem or bleeding disorder?				
When walking, do you ever have to stop because of pain in your chest or shortness of breath?				
Have you ever been hospitalized for any serious illnesses or operations? If yes, please explain below:				
Do you have or have you ever had any of the following? Please tick off only those that apply. □ chest pain □ bronchitis □ tuberculosis □ arthritis □ steroid therapy □ heart attack □ emphysema □ seizures/epilepsy □ diabetes □ pacemaker □ stroke □ asthma □ stomach ulcers □ kidney disease □ diet pill therapy □ prosthetic joint □ drug dependency/alcoholism □ thyroid problems □ cancer □ rheumatic fever □ heart murmur □ osteoporosis medications				
Are there any conditions or diseases not listed above that you have or have had? If so, please list:				
For women only, are you pregnant or breastfeeding? If pregnant, what is your due date? _____				
Do you smoke or chew tobacco? If so, how much? _____				

DENTAL HISTORY: Name and Address of Previous Dentist: _____

When was your last dental visit? _____ Reason: _____

When was the last time you had dental x-rays? _____

Have you ever had any of the following? Please tick off only those that apply.

□ Fillings
□ Regular cleanings
□ Periodontics (gum treatment)
□ Caps or crowns or bridges
□ Dental implants
□ Nitrous oxide (laughing gas)
□ Oral sedation
□ Intravenous sedation/anaesthesia
□ Extractions
□ An injury to your mouth or jaws
□ Root canal
□ Full or partial dentures
□ Orthodontics (braces)

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have you ever had a local anaesthetic (dental freezing)? □ Yes □ No If yes, any problems? □ No □ Yes, describe:_____

Would you be interested in having nitrous oxide (laughing gas) or another form of sedation for your dental treatment? □ Yes □ No

Would you like to improve the general cosmetic appearance of your teeth? □ Yes □ No

If yes, what would you like to change? _____

Do you presently have or think you may have any of the following? Please tick off only those that apply.

□ Loose teeth
□ Cavities
□ Gum disease
□ Sensitive teeth
□ Bleeding gums
□ A bad taste in your mouth
□ A clicking or sore jaw
□ Earaches and headaches
□ Unsightly or broken fillings
□ Dead or abscessed teeth
□ Bad breath
□ Grinding or clenching of teeth
□ Teeth not white enough
□ Crooked or mal-aligned teeth

In your own words, describe your present dental problem or needs: _____

OFFICE PHILOSOPHY AND POLICY (please read):

- In an effort to determine a treatment plan that is best for your overall dental health, we must make a careful diagnosis. This involves a thorough examination, often utilizing the minimum number of x-rays necessary for accuracy.
- We pledge to provide high quality dentistry in the most comfortable manner possible, with the best equipment, materials, and up-to-date techniques. The long-term success of our efforts will depend on the patient's willingness to maintain their teeth and help to prevent any future dental problems.
- Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we require 2 business days notice, or a cancellation fee may be charged. All urgent dental problems will be attended to the same day, under normal circumstances. You may call our office or answering service at any time.
- Our office policy is that services are paid for at each visit as they are performed. In certain circumstances, financial arrangements for payment may be made by consulting with the dentist or receptionist.
- **Regarding Insurance:** All patients with dental insurance are responsible for payment of their own accounts. We are pleased that you have insurance to reimburse or minimize your personal expenditure and we will gladly complete any claim forms to assist you in collecting your dental benefits. Please make certain you understand any limitations in your contract. We will gladly submit "estimate" forms, if necessary.
- **Regarding Your Privacy:** Protecting your personal information is important to us. We are committed to collecting, using, and disclosing your personal information responsibly, and try to be as transparent as possible about the way we handle this information. Please be assured that only necessary information is collected about you, we only share your information with your consent, and storage, retention, and destruction of this information complies with existing government legislation and privacy protection protocols as set out by the Royal College of Dental Surgeons of Ontario. In this office, Dr. Xiping (Michael) Liu is the Privacy Information Officer. More detail about our privacy policy is outlined in our Privacy Code, a copy of which you can view at any time by asking us for one.
- A healthy dentist-patient relationship is based on mutual respect and understanding. Please feel relaxed and open to discuss with us, any aspect of your treatment or fees, at any time.

CONSENT: I confirm that the above medical and dental information is true and complete to my knowledge. I have read and fully understand the policy regarding the payment of fees and will assume responsibility of fees associated with dental procedures performed. I consent to the collection, use and disclosure of personal information as stated above and discussed in more detail in the Privacy Code which I may ask to see at any time.

_____ _____ _____
Signature (Patient, parent, or guardian) Date Dentist's Signature

Follow-up information and updates to above questions (Dentist Use Only):

_____
_____
_____