DR. TAMARA JACKSON
DR. DANIEL ZEITER
DR. DANIEL WEITZ

PATIENT INFORMATION

(The following information is confidential and for our records only. Your confidence in our practice is greatly appreciated.)

Name (last / first) ______________________________

Title Mrs.________ Miss ________ Ms. ________ Mr. ________ Dr. ________

Sex ________ Weight ________ Height ________ Date of Birth (D/M/Y) ______________________ Age ________

Residence Address ______________________________

______________________________ Postal Code ______________

Res. Phone ______________ Cell ______________ Bus. Phone ______________

Email ______________________________

Would you prefer to be contacted by email ________ or by text ________

Name of Dentist ______________________ How long have you been under his/her care? ____________

Name & Address of Physician (Medical Doctor) ______________________________

____

Why were you referred to a periodontist? ______________________________

Person Responsible for this Account ______________________________

In Case of Emergency Please Notify ______________________________

Phone No. ______________________ Relationship to You ______________________

GENERAL HEALTH

What is your estimation of your general health? GOOD • FAIR • POOR (Circle appropriate one)

	Please Circle Yes or No	
Are you able to climb a flight of stairs comfortably?	YES	NO
Do you see your physician regularly?	YES	NO
If so, for what? ______________________________		
When was your last physical examination? ______________________		
Have you had any major operations, hospitalizations or illnesses?	YES	NO
If so, for what? ______________________________		
Are you taking any prescription medications, non-prescription medications, drugs, or natural supplements?	YES	NO
If so, please list: ______________________________		
Have you had any unusual reactions or allergies to any drugs, pills, medications or foods (such as: rashes, difficulty breathing, swelling, nausea etc.)?	YES	NO
If so, please list: ______________________________		
Are you required to take antibiotics prior to dental treatment?	YES	NO
If so, please list: ______________________________		

Have you ever had a reaction to any of the following: (PLEASE CHECK)

Codeine _____ Penicillin _____ Sleeping Pills _____ Nitrous Oxide _____ Latex _____ Foods (i.e.peanuts,eggs)_____
Aspirin _____ Sulfa Drugs _____ Clindamycin _____ Dental Anaesthetic _____ Metals (incl.nickel) _____

Do you currently smoke? How many cigarettes per day? _________ For how many years? _________ YES NO

Have you smoked in the past? YES NO

Do you drink alcohol regularly? How many drinks per day? ________________ YES NO

Are you on a diet of any kind? YES NO

Has any member of your biological family had malignant hyperthermia, tuberculosis, diabetes, heart disease, bleeding problems or cancer? (PLEASE CIRCLE WHICH) If yes, who? _________________________ YES NO

Do you have or have you ever had: (PLEASE CHECK)

_______ Rheumatic fever
_______ Heart Murmur
_______ Artificial Heart Valve
_______ Angina
_______ Heart Attack
_______ Arteriosclerosis (high cholesterol)
_______ High or Low Blood Pressure
_______ Anemia or Leukemia
_______ Blood transfusions
_______ Bleeding or Bruising tendencies
_______ Stroke
_______ Allergies
_______ Asthma or difficulty breathing
_______ Sinus problems
_______ Tuberculosis
_______ Emphysema or other lung disease
_______ Shortness of breath, pain upon physical exertion
_______ Sleep Apnea
_______ Frequent headaches, dizziness or light headedness
_______ Epilepsy, seizures, convulsions, fainting spells
_______ Glaucoma
_______ Malignant hyperthermia
_______ Abnormal thirst
_______ Diabetes
_______ Thyroid or Parathyroid disease
_______ Swelling of hands, feet or eyes
_______ Conditions requiring cortisone or steroid use
_______ Hepatitis, jaundice, or other liver diseases
_______ Painful or frequent urination
_______ Kidney disease or bladder trouble
_______ Heartburn, gastric reflux or stomach ulcer
_______ Frequent vomiting or diarrhea
_______ Painful or swollen joints
_______ Frequent fractures or dislocations
_______ Arthritis or Rheumatism
_______ Joint Replacement or Prosthesis
_______ Tumors or growths
_______ X-ray or radiation therapy
_______ Rash or skin disorders
_______ Immune deficiencies (HIV, AIDS, Leukemia)
_______ Problems in healing
_______ Clinical depression or anxiety
_______ Are you a blood donor

Do you have difficulty breathing when you lie down? YES NO

Have you recently gained or lost excessive amounts of weight? YES NO

Have you had abnormal bleeding after a cut or tooth extraction? YES NO

WOMEN ONLY:

Are you pregnant? YES NO

Are you nursing? YES NO

Have you reached menopause (Change of Life)? YES NO

Is there anything else that you would like to add: ____

____

____

DENTAL HEALTH

Do you consider yourself in good dental health?	YES	NO
Do you think that your teeth are affecting your health in any way?	YES	NO
Are you dissatisfied with the appearance of your teeth?	YES	NO
Are you dissatisfied with your chewing ability?	YES	NO

Have you ever had:
- ❑ Orthodontic treatment (Braces)
- ❑ Oral Surgery (Extraction, etc.)
- ❑ Periodontal treatment (by a Periodontist)
- ❑ Your bite adjusted
- ❑ A bite guard or other dental appliance

Have you ever been in a vehicle accident or experienced any trauma to your jaws?	YES	NO
Have you noticed any loosening or drifting of your teeth?	YES	NO
Does food tend to get caught between your teeth?	YES	NO
Do you suffer from pain and/or swelling of your gums?	YES	NO
Do your gums bleed when you brush your teeth?	YES	NO
Has anyone in your family lost teeth at a young age or had gum disease?	YES	NO

Do you:
- ❑ Clench or grind your teeth while awake or asleep?
- ❑ Bite your lips or cheeks regularly?
- ❑ Hold foreign objects in your teeth?
- ❑ Breathe primarily through your mouth?

When was your last dental cleaning? ____________________

How long before that? ____________________

How often before that? ____________________

How often and when do you brush your teeth? ____________________

Do you use: ❑ Hand toothbrush ❑ Electric toothbrush

Is your toothbrush: ❑ Soft ❑ Medium ❑ Hard

What do you use to clean between your teeth? (floss, toothpick, waterpick, etc.) ____________________

How often? ____________________

Do you feel apprehensive when you are having dental treatment?	YES	NO
Would you like to be sedated during treatment?	YES	NO
Does the fear of pain make you postpone your dental treatment?	YES	NO
Have you had a bad dental experience?	YES	NO
Would you like to elaborate? ____________________	YES	NO

____

____

I verify that all of the information given is true to the best of my knowledge.

Signature ____________________ Date (DD/MM/YY) ____________________

Name: ____

Address: ______________________________ DOB (dd/mm/yy) ________________

____

What medication am I taking?	**Why am I taking this medication?**	**How often do I take it? What dosage?**	**When did I start/stop?**	**Who prescribed it to me?**

If you would like to have your dental claim submitted electronically to your PRIMARY INSURANCE, please fill out the following form so that we can send your claim for you during your visit. If you have secondary insurance coverage please provide the information on this form and we will provide a claim form for you to submit by mail. You will still make payment to our office on day of the treatment but you will still receive your insurance reimbursement faster, often in three days.

Primary Insurance

Name of Patient ____________________

Date of Birth (d/m/y) ____________________

Address of Patient ____________________

Name of Subscriber ____________________
(Insurance Holder)

Date of Birth (d/m/y) ____________________

Relationship to Patient ____________________

Name of Insurance Company ____________________

Name of Employer ____________________
(Past or Present)

Group Plan or Policy Number ____________________

Plan Division Number ____________________

Certificate or I.D Number (Not all plans have) ____________________

If the patient is attending school, please provide us with the name of the school.

____

If you have secondary insurance coverage please provide secondary insurance information on next page.

Secondary Insurance

Name of Patient ______________________________

Date of Birth (d/m/y) ______________________________

Address of Patient ______________________________

Name of Subscriber ______________________________
(Insurance Holder)

Date of Birth (d/m/y) ______________________________

Relationship to Patient ______________________________

Name of Insurance Company ______________________________

Name of Employer ______________________________
(Past or Present)

Group Plan or Policy Number ______________________________

Plan Division Number ______________________________

Certificate or I.D Number (Not all plans have) ______________________________

PATIENT CONSENT FORM:

FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The 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 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. Daniel J. Zeiter 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 any member of our office staff or myself.

Please be assured that every 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 your information.

Our 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 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 mandate under the RHPA, and for the deference 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 Dr. Daniel J. Zeiter, Associates, and Staff 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