PATIENT INFORMATION FORM

Child's Information

Last Name		First Name	
Date of Birth		Gender	
Address			
City		Postal Code	
Phone (Home)		Phone (Cell)	
Mother's Name		Email	
Occupation		Work Phone	
Father's Name		Email	
Occupation		Work Phone	
Physician/Pediatrician		Office Phone	
Previous Family Dentist		Office Phone	
Insurance Company			
Policy Number		Certificate Number	
Subsriber's Name			
Date of Birth		Employer	
How did you hear about our office?			

Medical History

A current and detailed medical history is required to enable us to provide our patients with the best dental care for their specific needs, and to ensure all treatment is delivered safely and effectively.

Question		
Is the patient seen for regular medical check ups by a medical doctor or nurse practitioner?	Yes	No
Is the patient up to date on their vaccine schedule?	Yes	No
Is the patient currently taking any medications or supplements? (Please list)	Yes	No
(Please list)		
Does the patient have any allergies to medications, foods or environmental sources?	Yes	No
(Please list)		
Has the patient ever been hospitalized?	Yes	No
(Please detail)		

Has the patient ever had any surgery or general anesthetic?	Yes No
(Please detail)	
Does the patient have any bleeding problems or clotting disorders?	Yes No
(Please detail)	
Does the patient have any cardiac (heart) or respiratory (breathing) conditions?	Yes No
(Please detail)	
Does the patient have any developmental, attention, language, social, or learning deficits?	Yes No
(Please detail)	

Has the patient ever had/used/been: (please check all that apply)

leukemia	cancer	anaemia	diabetes
AIDS/HIV	liver problems	seizures	metabolic disorders
radio/chemotherapy	kidney problems	chicken pox	cigarettes/tobacco
rheumatic fever	bowel problems	steroid therapy	illicit drugs
			pregnant

Dental History

Has the patient ever seen a dentist before? Yes No	Date of last visit	

Are there any specific dental concerns to be addressed? Yes No	
If yes, tell us more:	
Does the patient have any oral habits? (e.g. thumb or lip sucking, soothers, nail biting etc.) Yes No	
If yes, tell us more:	
Has the patient previously had any dental trauma or other injuries to the mouth? Yes No	
If yes, tell us more:	

Emergency Contact

Name		Relationship	
Phone		Cell	

Scheduling: Your appointment time is reserved specifically for you /and your child. We are happy to reschedule your appointment without a fee up to 48 hrs in advance. Please note that we make every effort to keep our appointments on time. To accomplish this we ask that you arrive promptly for your appointment and be understanding that some appointments may run longer than intended, because of the unpredictable nature of pediatric dentistry. We ask you to extend this consideration to other patients and parents as they would for you.

Financials: This office operates on a fee-for-service basis; payment for the day's treatment is due on the day of treatment and can be paid by debit, credit card or cash. Your dental insurance is a contract between you and your insurance provider and does not involve this office. Our treatment plans are based on your child's dental needs and not insurance coverage. We are happy to help you fill out, and in many cases submit, your insurance claims for you. Alternative arrangements such as direct billing or payment plans may be considered or an individual basis, please inquire if this is necessary.

The information provided herein is accurate and to the best of my knowledge. I have read, understand and agree to all the above information and terms.

Signature (parent or guardian if patient is under 18 yrs)		Date	

Durham Kids Dentistry
5 - 10 Meadowglen Dr
Whitby, L1R 3P8

PATIENT CONSENT FORM:
COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Privacy of your child's personal health information is an important part of our office providing quality dental care. We understand the importance of protecting this personal health information. We are committed to collecting, using and disclosing this personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients. Dr. Evan Zaretsky is our contact person for personal health information related matters.

All staff members who come in contact with your personal health 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 and your child;
- we only share this information with your consent;
- storage, retention and destruction of this personal health 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 local, provincial and federal laws.

Do not hesitate to discuss our policies with me or any member of our office staff

How Our Office Collects, Uses and Discloses Patients' Personal Health Information

Our office understands the importance of protecting personal health information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing this information.
This office will collect, use and disclose personal health information about your child for the following purposes:

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your child's 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 child's personal health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.
Your child's personal health 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.
You may withdraw your consent for use or disclosure of your child's personal health information at any time.

Patient Consent

I have reviewed the above information that explains how your office will use my child's personal health information, and the steps your office is taking to protect this information.
I agree that Dr. Evan Zaretsky can collect, use and disclose personal health information about

____(Name of Patient) as set out above in the information about the office's privacy policies.

______________________________	______________________________
Name of Patient	Print Name of Parent / Guardian
______________________________	______________________________
Signature	Date