PLEASE PRINT

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST, FIRST MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PREFER TO BE CALLED	HOME PHONE #	CELL PHONE #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	E-MAIL

MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

SPOUSE'S NAME LAST, FIRST MI	SPOUSE'S EMPLOYER	OCCUPATION

SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP	WORK PHONE #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP

HOME PHONE #	WORK PHONE #	CELL PHONE #

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐

PLEASE PRINT

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO
Health Care Providers	☐	☐
Insurance Companies	☐	☐

OTHERS (PLEASE PRINT)

1.

2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers, demonstrations and/or presentations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS 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 our office, **Dr. Charles Triassi** 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 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.

This 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 of 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 reviews of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- to permit potential purchases, 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
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist the office to comply with all regulatory requirements
- to comply generally with the law

By signing the consent section of this 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 above. 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 defence 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 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 West Village Dental Clinic (Dr. Charles Triassi) 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

DENTAL HISTORY

Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Previous Dentist _____ How long have you been a patient? _____ Months / Years

Date of the most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____

Date of most recent treatment (other than a cleaning) / /

I routinely see my dentist every ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) (____) _____ ❑ ❑
2. Have you had an unfavorable dental experience? _____ ❑ ❑
3. Have you ever had complications from past dental treatment? _____ ❑ ❑
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ❑ ❑
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ❑ ❑
6. Have you ever had any teeth removed? _____ ❑ ❑

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ❑ ❑
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ❑ ❑
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ❑ ❑
10. Is there anyone with a history of periodontal disease in your family? _____ ❑ ❑
11. Have you ever experienced gum recession? _____ ❑ ❑
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ❑ ❑
13. Have you experienced a burning sensation in your mouth? _____ ❑ ❑

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ❑ ❑
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ❑ ❑
16. Do you feel or notice any holes (i.e. pitting craters) on the biting surface of your teeth? _____ ❑ ❑
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ❑ ❑
18. Do you have grooves or notches on your teeth near the gum line? _____ ❑ ❑
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ❑ ❑
20. Do you frequently get food caught between any teeth? _____ ❑ ❑

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ❑ ❑
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ❑ ❑
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ❑ ❑
24. Have your teeth changed in the last 5 years, become shorted, thinner or worn? _____ ❑ ❑
25. Are your teeth crowding or developing spaces? _____ ❑ ❑
26. Do you have more than one bite and squeeze to make your teeth fit together? _____ ❑ ❑
27. Do you chew ice, bit your nails, use your teeth to hold objects, or have any other habits? _____ ❑ ❑
28. Do you clench your teeth in the daytime or make them sore? _____ ❑ ❑
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ❑ ❑
30. Do you wear or have you ever worn a bite appliance? _____ ❑ ❑

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? _____ ❑ ❑
32. Have you ever whitened (bleached) your teeth? _____ ❑ ❑
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ❑ ❑
34. Have you been disappointed with the appearance of previous dental work? _____ ❑ ❑

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician / and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES** **NO**

1. hospitalization for illness or injury _____ ❑ ❑
2. an allergic reaction to
   - ❑ asprin, ibuprofen, acetaminophen, codeine
   - ❑ penicilin
   - ❑ erythromycin
   - ❑ tetracycline
   - ❑ sulfa
   - ❑ local anesthetic
   - ❑ fluoride
   - ❑ metals (nickel, gold, silver, _____)
   - ❑ latex
   - ❑ other
3. heart problems, or cardiac stent within the last six months ___ ❑ ❑
4. history of infective endocarditis _____ ❑ ❑
5. artificial heart valve, repaired heart defect (PFO) _____ ❑ ❑
6. pacemaker or implantable defibrilator _____ ❑ ❑
7. artificial prosthesis (heart valve or joints) _____ ❑ ❑
8. rheumatic or scarlet fever _____ ❑ ❑
9. high or low blood pressure _____ ❑ ❑
10. a stroke (taking blood thinners) _____ ❑ ❑
11. anemia or other blood disorder _____ ❑ ❑
12. prolonged bleeding due to a slight cut (INR > 3.5) _____ ❑ ❑
13. emphysema, shortness or breath, sancoidosis _____ ❑ ❑
14. tuberculosis, measles, chicken pox _____ ❑ ❑
15. asthma _____ ❑ ❑
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ❑ ❑
17. kidney disease _____ ❑ ❑
18. liver disease _____ ❑ ❑
19. jaundice _____ ❑ ❑
20. thyroid, parathyroid disease, or calcium deficency _____ ❑ ❑
21. hormone deficiency _____ ❑ ❑
22. high cholesterol or taking statin drugs _____ ❑ ❑
23. diabetes (HbA1c=_____) _____ ❑ ❑
24. stomach or duodenal ulcer _____ ❑ ❑
25. digestive disorders (i.e. celiac disease, gastric reflux) _____ ❑ ❑

YES **NO**

26. osteoporosis / osteopenia (i.e. taking bisphosphonates) ❑ ❑
27. arthritis, rheumatoid arthritis, lupus _____ ❑ ❑
28. glaucoma _____ ❑ ❑
29. contact lenses _____ ❑ ❑
30. head or neck injuries _____ ❑ ❑
31. epilepsy, convulsions (seizures) _____ ❑ ❑
32. neurologic disorders (ADD / ADHD, prion disease) _____ ❑ ❑
33. viral infections and cold sores _____ ❑ ❑
34. any lumps or swelling in the mouth _____ ❑ ❑
35. hives, skin rash, hay fever _____ ❑ ❑
36. STI / STD _____ ❑ ❑
37. hepatitis (type ___) _____ ❑ ❑
38. HIV / AIDS _____ ❑ ❑
39. tumor, abnormal growth _____ ❑ ❑
40. radiation therapy _____ ❑ ❑
41. dhemotherapy, immunosuppressive _____ ❑ ❑
42. emotional problems _____ ❑ ❑
43. psychiatric treatment _____ ❑ ❑
44. antidepressant medication _____ ❑ ❑
45. alcohol / street drug use _____ ❑ ❑

ARE YOU:

46. presently being treated for other illness _____ ❑ ❑
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____ ❑ ❑
48. taking medication for weight management (i.e. fen-phen) ❑ ❑
49. taking dietary supplements _____ ❑ ❑
50. often exhausted or fatigued _____ ❑ ❑
51. experiencing frequent headaches _____ ❑ ❑
52. a smoker, smoked previously or use smokeless tobacco ❑ ❑
53. considered a touchy person _____ ❑ ❑
54. often unhappy or depressed _____ ❑ ❑
55. FEMALE - taking birth control pills _____ ❑ ❑
56. FEMALE - pregnant _____ ❑ ❑
57. MALE - prostate disorders _____ ❑ ❑

Describe any current medical treatment, impending surgery, generic / development delay, or other treatment that may possibly affect your dental treatment (i.s. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two tears

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Patient's Signature _____ Date _____