Diane M Ruud Orthodontic Associates

Welcome to our office. To become better acquainted and to be able to offer you the best possible orthodontic care, we would ask that you please complete this Personal Information & Consent Form.

** All information will be kept in strict confidence **

WE SEEK TO PROTECT YOUR PRIVACY WHILE PROMOTING YOUR ORAL HEALTH

Date:_____ Examination Date:_____ Our Account No:_____
Patient's Last Name:_____ First Name:_____
Middle Name/Initial:_____ Prefers to be called:_____
Birth Date:_____ Age:_____ Sex: Male ____ Female _____
Height:_____ Weight:_____ E-Mail Address:_____
Address:_____ City:_____ Province:_____
Postal Code:_____ Home Phone No:(___)_____
Other family members treated here:_____

Custodial Parent(s) or Guardian(s):_____
Salutation: Dr._____ Mr._____ Mrs._____ Ms. _____ Miss_____
Address (if different than patient's):_____ City:_____
Province:_____ Postal Code:_____ E-Mail Address:_____
Phone No. (if different than patient's):(____)_____ Cell Phone No:(____)_____

Who is Financially Responsible for this Account? Relationship to Patient:_____
Last Name:_____ First Name:_____
Address (if different than patient's):_____ City:_____
Province:_____ Postal Code:_____ E-Mail Address:_____
Phone No. (if different than patient's):(____)_____ Cell Phone No:(____)_____
Employer:_____ Work Phone No:(____)_____

Insurance Coverage for: Dental Treatment: Yes No Orthodontic Treatment: Yes No
Dental Insurance Company: _____

Name of Patient's Dentist:_____ Phone No:(____)_____
Date Last Seen:_____ Reason:_____

Name of Patient's Physician(s):_____ Phone No:(____)_____
Date Last Seen:_____

Who suggested that your child might need orthodontic treatment?_____
Why did you select our office?_____

OFFICE INSURANCE POLICY

**** As per the Canadian Association of Orthodontists Insurance Guidelines ****

Our policy is to have patients/parents pay our office directly for all orthodontic services provided. Our contract does not include fees for services not provided by our office ie: regular dental checkups, extractions, surgery, periodontal, etc. Upon receipt of payment, we will provide Standard Dental Claim Forms which may be submitted to your Insurance Carrier(s) for reimbursement.

Orthodontic Office Personal Information Consent Form

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, and work telephone numbers. (Collectively referred to as "Contact Information"). Contact Information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies.
- To send reminders to patients concerning the need for further dental examination or treatment.
- To send patients informational material about our dental practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on their behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing orthodontic treatment.
Patients' Medical Information is disclosed:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patients' behalf.
- To other dentists and dental specialists in the following situations:
  - where we are seeking a second opinion and the patient has consented to us obtaining a second opinion.
  - where the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.
  - where those dentists have asked us, with the consent of the patient, to provide a second opinion
- To other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment.

If we are ever considering selling all or part of our orthodontic practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest.
I consent to the collection, use and disclosure of my personal information as set out above.

PRINTED NAME of Patient/Parent/Guardian _____

SIGNATURE _____ DATE _____

For the following questions please mark YES or NO. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

Y N Does patient brush his/her teeth conscientiously?
Y N Does patient have learning disabilities or need extra help with instructions?
Y N Is patient sensitive or self-conscious about teeth?

MEDICAL HISTORY

Now or in the past, has the patient had:

Y N Birth defects or hereditary problems?
Y N Rheumatoid or arthritic conditions?
Y N Kidney problems?
Y N Cancer, tumor, radiation treatment or chemotherapy?
Y N Polio, mononucleosis, tuberculosis or pneumonia?
Y N Fainting spells, seizures, epilepsy or neurological problem?
Y N Mental health disturbance or behavioral problem?
Y N Vision, hearing, tasting or speech difficulties?
Y N Does the patient eat a well-balanced diet?
Y N History of eating disorder (anorexia, bulimia)?
Y N Excessive bleeding or bruising tendency, anemia or bleeding disorder?
Y N Bone fractures, any major accidents?
Y N Endocrine or thyroid problems?
Y N Diabetes?
Y N Stomach ulcer or hyperacidity?
Y N Problems of the immune system?
Y N AIDS or HIV positive?
Y N Hepatitis, jaundice or liver problem?
Y N Loss of weight recently, poor appetite?
Y N High or low blood pressure?
Y N Tires easily?
Y N Skin disorder?
Y N Frequent headaches, colds or sore throats?
Y N Tonsil or adenoid conditions?
Y N Hay fever, asthma, sinus trouble or hives?
Y N Chest pain, shortness of breath or swelling ankles?
Y N Eye, ear, nose or throat condition?
Y N Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

Allergies or reactions to any of the following:

Y N Local anesthetics (Novocaine or Lidocaine)
Y N Ibuprofen (Motrin, Advil)
Y N Sulfa drugs
Y N Metals (jewelry, clothing snaps)
Y N Vinyl
Y N Animals
Y N Aspirin
Y N Acetaminophen (Tylenol)
Y N Penicillin or other antibiotics
Y N Codeine or other narcotics
Y N Latex (gloves, balloons)
Y N Acrylic
Y N Foods (specify _____)
Y N Other substances (specify _____)
Y N Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

Y N Does the patient currently have or ever had a substance abuse problem?
Y N Does the patient chew or smoke tobacco?
Y N Operations? Describe: _____
Y N Hospitalized? For: _____

Y N Other physical problems or symptoms? Describe: _____

Y N Being treated by another health care professional? For: _____

Date of most recent physical exam: _____

Are there any other medical conditions that we should be aware of? _____

GIRLS ONLY

Y N Has the patient started her monthly periods? If so, at what age? _____

Y N Is the patient pregnant?

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

Bleeding disorders _____

Diabetes _____

Arthritis _____

Metabolic disturbances _____

Severe allergies _____

Unusual dental problems _____

Jaw size imbalance _____

Are there any other family medical conditions that we should know about? _____

DENTAL HISTORY

Now or in the past, has the patient had:

Y N Started teething very early or late?

Y N Primary (baby) teeth removed that were not loose?

Y N Permanent or "extra" (supernumerary) teeth removed?

Y N Supernumerary (extra) or congenitally missing teeth?

Y N Chipped or otherwise injured primary (baby) or permanent teeth?

Y N Jaw fractures, cysts or mouth infections?

Y N Thumb, finger, or sucking habit? Until what age ___?

Y N Abnormal swallowing habit (tongue thrusting)?

Y N History of speech problems?

Y N Mouth breathing habit, snoring or difficulty in breathing?

Y N Tooth grinding, jaw clenching, clicking or locking?

Y N Any pain in jaw or ringing in the ears?

Y N Concerned about spaced, crooked or protruding teeth?

Y N Aware or concerned about under or over developed jaw?

Y N Any relative with similar tooth or jaw relationships?

Y N Would patient object to wearing orthodontic appliances (braces) should they be indicated?

Y N Ever had a prior orthodontic examination or treatment?

I have read and understand the above questions. I will not hold my orthodontist or any member of his/her staff responsible for any error or omissions that I have made in the completion of this form. If there are any changes later to this history records or medical/dental status, I will inform this practice.

_____ _____

Printed Name of Parent or Guardian Signature

_____ _____

Dental Staff Member as Witness Date