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.

WE SEEK TO PROTECT YOUR PRIVACY WHILE PROMOTING YOUR ORAL HEALTH

Date:________________ Examination Date:______________ Our Account No:__________

Patient's Last Name:________________________ First Name:________________________

Prefers to be called:________________________ Salutation: Mr. Dr. Mrs. Ms. Miss

Birth Date: Year _____ Month _____ Day _____ Age _____

Height: ______________ Weight:___________ Gender: Male Female Other

Address: ____________________________ City: ____________________ Province:_______

Postal Code: _______________ E-Mail Address: ________________________________

Phone Numbers: cell _____________ home _______________ work ___________

Patient is: Single Married Widowed Separated Divorced

Name of Spouse: __________________________

Other family members treated here:______________________________________

Who is Financially Responsible for this Account?

Last Name:_______________ First Name:_______________ relationship to pt:__________

Address (if different than patient's):____________________________ City:_______________

Province:_____________ Postal Code:__________ E-Mail Address:_____________________

Phone (if different than patient's): cell _____________ home _______________ work __________

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 you might need orthodontic treatment?___________________________

Why did you select our office?______________________________

OFFICE INSURANCE POLICY

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 and phone numbers, work addresses and phone numbers, email addresses and cell 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, to collect unpaid accounts, or to make financial arrangements for payment of services.
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies.
- To provide pre-authorization forms to 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.

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 their 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.

* I understand that I have the right to withdraw consent at anytime.

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 (Printed Name) ____ (Please cirle) **Patient** **Guardian**

☐ **CONSENT** ☐ **DO NOT CONSENT** to the collection, use and disclosure of personal information as set out above.

SIGNATURE ____ DATE ____________________

For further information, please see our office Privacy Officer – Kathy Langlois

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.

Now or in the past, have you had:

YES	NO		YES	NO	
___	___	Birth defects or hereditary problems?	___	___	Bone fractures, any major accidents?
___	___	Rheumatoid or arthritic conditions?	___	___	Endocrine or thyroid problems?
___	___	Kidney problems?	___	___	Diabetes?
___	___	Cancer, tumor, radiation treatment or chemotherapy?	___	___	Stomach ulcer or hyperacidity?
			___	___	Problems of the immune system?
___	___	Polio, mononucleosis, tuberculosis or pneumonia?	___	___	AIDS or HIV positive?
			___	___	Hepatitis, jaundice or liver problem?
___	___	Fainting spells, seizures, epilepsy or neurological problem?	___	___	Mental health disturbance or depression?
			___	___	Loss of weight recently, poor appetite?
___	___	Vision, hearing, tasting or speech difficulties?	___	___	High or low blood pressure?
___	___	History of eating disorder (anorexia, bulimia)?	___	___	Tires easily?
___	___	Excessive bleeding or bruising tendency, anemia or bleeding disorder?	___	___	Skin disorder?
			___	___	Do you have a well-balanced diet?
___	___	Chest pain, shortness of breath or swelling ankles?	___	___	Frequent headaches, colds or sore throats?
			___	___	Eye, ear, nose or throat condition?
___	___	Hay fever, asthma, sinus trouble or hives?	___	___	Tonsil or adenoid conditions?
___	___	Osteoporosis?			
___	___	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:

YES	NO		YES	NO	
___	___	Local anesthetics (Novocaine or Lidocaine)	___	___	Aspirin
___	___	Ibuprofen (Motrin, Advil)	___	___	Penicillin or other antibiotics
___	___	Sulfa drugs	___	___	Codeine or other narcotics
___	___	Metals (jewelry, clothing snaps)	___	___	Acetaminophen (Tylenol)
___	___	Vinyl	___	___	Latex (gloves, balloons)
___	___	Animals	___	___	Acrylic

___ ___ Foods (specify) ______________________________

___ ___ Other substances (specify) ______________________________

___ ___ Are you taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication ____________________ Taken for ____________________

Medication ____________________ Taken for ____________________

Medication ____________________ Taken for ____________________

___ ___ Do you currently have or ever had a substance abuse problem?

___ ___ Do you chew or smoke tobacco?

___ ___ Operations? Describe: ______________________________

___ ___ Hospitalized? For: ______________________________

___ ___ Other physical problems or symptoms? Describe: ______________________________

___ ___ Being treated by another health care professional?

For: ____________________ Date of most recent physical exam: ____________

Do you have any other medical conditions that we should know about? ______________________________

Do your parents or siblings have, or have ever had any of the following health problems? If so, please explain.

Arthritis ______________________________

Unusual dental problems ______________________________

Jaw size imbalance ______________________________

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

____

WOMEN ONLY

YES NO

___ ___ Are you pregnant?

___ ___ Are you anticipating becoming pregnant?

DENTAL HISTORY

Now or in the past, have you had:

YES NO

___ ___ Permanent or "extra" (supernumerary) teeth removed?
___ ___ Supernumerary (extra) or congenitally missing teeth?
___ ___ Chipped or otherwise injured primary (baby) or permanent teeth?
___ ___ Teeth sensitive to hot or cold; teeth throb or ache?
___ ___ Jaw fractures, cysts or mouth infections?
___ ___ "Dead teeth" or root canals treated?
___ ___ Bleeding gums, bad taste or mouth odor?
___ ___ Periodontal "gum problems"? If yes, had treatment done by: ______________________________
___ ___ Food impaction between teeth?
___ ___ "Gum boils", frequent canker sores or cold sores?
___ ___ Thumb, finger, or sucking habit? Until what age ______?
___ ___ Abnormal swallowing habit (tongue thrusting)?
___ ___ History of speech problems?
___ ___ Mouth breathing habit, snoring or difficulty in breathing?
___ ___ Tooth grinding or jaw clenching?
___ ___ Any pain, clicking or locking in jaw or ringing in the ears?
___ ___ Any pain or soreness in the muscles of the face or around the ears?
___ ___ Difficulty in chewing or jaw opening?
___ ___ Have you ever been treated for "TMD" or "TMJ" problems?
___ ___ Aware of loose, broken or missing restorations (fillings)?
___ ___ Any teeth irritating cheek, lip, tongue or palate?
___ ___ Concerned about spaced, crooked or protruding teeth?
___ ___ Aware or concerned about under or over developed jaw?
___ ___ Any relative with similar tooth or jaw relationships?
___ ___ Any wisdom tooth problems?
___ ___ Had any serious trouble associated with any previous dental treatment?
___ ___ Been under another dentist's care?
Specialist ___________________?
Other ______________________?
___ ___ Ever had a prior orthodontic examination or treatment?
___ ___ Would you object to wearing orthodontic appliances (braces) should they be indicated?

How often do you brush:____________________ floss:_____________________
What is your primary concern? Why are you here? ____

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.

____________________________________ ____________________________________
Print Name (Patient, Parent or Guardian) Signature

____________________________________ _____________________________
Dental Staff Member as Witness Date