Under 18

# 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:_____
Middle Name/Initial:_____ Prefers to be called:_____
Birth Date: Year ____ Month_____ Day____ Age____ Gender: Male ____ Female ____ Other _____
Height:_____ Weight:_____ E-Mail Address:_____
Address:_____ City:_____ Province:_____
Postal Code: _____ Phone: cell _____ home _____
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: (if different than patient's): cell _____ home _____ work _____

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: (if different than patient's): cell _____ home _____ work _____
Employer:_____

Insurance Coverage for: General Dental care: Yes____ No ____ Orthodontics: 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

**Our contract does not include fees for services not provided by our office ie: extractions, regular dental checkups, 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 circle) **Parent** **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 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.**

YES NO

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

**Now or in the past, has the patient had:**

YES NO

___ ___ Birth defects or hereditary problems?
___ ___ Rheumatoid or arthritic conditions?
___ ___ Kidney problems?
___ ___ Cancer, tumor, radiation treatment or chemotherapy?
___ ___ Polio, mononucleosis, tuberculosis or pneumonia?
___ ___ Fainting spells, seizures, epilepsy or neurological problem?
___ ___ Mental health disturbance or behavioral problem?
___ ___ Vision, hearing, tasting or speech difficulties?
___ ___ Does the patient eat a well-balanced diet?
___ ___ History of eating disorder (anorexia, bulimia)?
___ ___ Excessive bleeding or bruising tendency, anemia or bleeding disorder?
___ ___ Eye, ear, nose or throat condition?
___ ___ Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?

YES NO

___ ___ Bone fractures, any major accidents?
___ ___ Endocrine or thyroid problems?
___ ___ Diabetes?
___ ___ Stomach ulcer or hyperacidity?
___ ___ Problems of the immune system?
___ ___ AIDS or HIV positive?
___ ___ Hepatitis, jaundice or liver problem?
___ ___ Loss of weight recently, poor appetite?
___ ___ High or low blood pressure?
___ ___ Tires easily?
___ ___ Skin disorder?
___ ___ Frequent headaches, colds or sore throats?
___ ___ Tonsil or adenoid conditions?
___ ___ Hay fever, asthma, sinus trouble or hives?
___ ___ Chest pain, shortness of breath or swelling ankles?

**Allergies or reactions to any of the following:**

___ ___ Local anesthetics (Novocaine or Lidocaine)
___ ___ Ibuprofen (Motrin, Advil)
___ ___ Sulfa drugs
___ ___ Metals (jewelry, clothing snaps)
___ ___ Vinyl
___ ___ Animals
___ ___ Foods (specify _____)
___ ___ Other substances (specify _____)
___ ___ Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

___ ___ Aspirin
___ ___ Acetaminophen (Tylenol)
___ ___ Penicillin or other antibiotics
___ ___ Codeine or other narcotics
___ ___ Latex (gloves, balloons)
___ ___ Acrylic

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

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

YES NO

___ ___ Other physical problems or symptoms? Describe: _____

___ ___ 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

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

___ ___ 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:**

YES NO

___ ___ Started teething very early or late?

___ ___ Primary (baby) teeth removed that were not loose?

___ ___ Permanent or "extra" (supernumerary) teeth removed?

___ ___ Supernumerary (extra) or congenitally missing teeth?

___ ___ Chipped or otherwise injured primary (baby) or permanent teeth?

___ ___ Jaw fractures, cysts or mouth infections?

___ ___ 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, jaw clenching, clicking or locking?

___ ___ Any pain in jaw or ringing in the ears?

___ ___ Concerned about spaced, crooked or protruding teeth?

___ ___ Aware or concerned about under or over developed jaw?

___ ___ Any relative with similar tooth or jaw relationships?

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

___ ___ 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