KAWARTHA ENDODONTICS
SPECIALIZING IN ROOT CANAL THERAPY

First Name: _____ Last Name: _____

Date of Birth: _____mm / _____ dd / _____ yy

Mailing Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____ **Email** _____

Your Employer/Occupation : _____ Name of your Spouse : _____ Dental Benefits?: YES NO

Primary Ins. Co. _____ **Ins. Holder Name & DOB** _____ **Policy #** _____**ID** _____

Secondary Ins. Co. _____ **Ins. Holder Name & DOB** _____ **Policy #** _____**ID** _____

Where did you hear about Kawartha Endodontics ? _____Newspaper _____Radio _____ Referral from your dental office___

ARE YOU UP DATE ON YOUR IMMUNIZATIONS? _____

- Do you have any **ALLERGIES** to any anaesthetics/antibiotics or medications?
  If NO . . . Please INITIAL HERE _____ **IF YES please list.** _____
- Have you ever had **sedation** for a dental appointment? ☐YES ☐NO **Your current Weight** _____**lbs**
- **If yes,** circle which type of sedation you had. Is it N20 (laughing gas) / ORAL SEDATION (pill) / IV SEDATION
  Excluding Local anaesthetic (freezing) .

Have you ever had abnormal bleeding with previous surgery, extractions or trauma? ☐YES☐NO

- Are you required to take a **pre-med antibiotic** prior to **ALL DENTAL TREATMENT**?☐YES☐NO
- How much discomfort are you experiencing? _____ Scale of 1 –10 (10 being EXTREME pain)
- How important is keeping your natural teeth?_____ Scale of 1 –10 (10 being VERY IMPORTANT)
- Have you ever had an **unfavourable reaction** to a dental appointment?☐YES☐NO

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD:

☐ High Blood Pressure	☐ Tuberculosis	☐ Dialysis
☐ Emphysema	☐ Irregular Heart Beat	☐ Heart Surgery/Bypass
☐ Joint Prosthesis	☐ Radiation or Chemotherapy	☐ Bronchitis, Chronic Cough
☐ Rheumatic Fever/Heart Disease	☐ Hepatitis A B C	☐ Hay Fever
☐ Congenital Heart Disease	☐ Eye Disease/Glaucoma	☐ Immune System Problems
☐ Cardiovascular Disease	☐ Sinus Troubles	☐ Lung/Breathing Problems
☐ Prosthetic Heart Valve	☐ Thyroid Problems	☐ Chronic Fatigue
☐ Blood Disorder	☐ Diabetes	☐ History of Drug Abuse
☐ Asthma	☐ Stomach Ulcers/Colitis	☐ Wear Contact Lenses
☐ Latex Allergy	☐ Hepatitis, Jaundice, Liver Disease	☐ Bruise Easily
☐ Low Blood Pressure	☐ Psychiatric Treatment	☐ Gallbladder Troubles
☐ Chest Pain/Angina	☐ Fainting Spells	☐ Arthritis
☐ Epilepsy	☐ Low Blood Sugar	☐ Delayed Healing
☐ Cardiac Pacemaker	☐ Cancer	☐ TMJ Problems

Do you have a new/worse cough or shortness of breath? _____
Are you feeling feverish? _____
Have you traveled in the last 14 days? _____ If so, where ? _____
Have you had contact with a sick person who has traveled in the last 14 days? _____
Where did the person travel? _____

- Do you have any diseases or conditions not listed above? _____
- Are you taking any prescribed medications? If yes, please list or provide separately on back of page :
  _____
- Have you ever tested **POSITIVE** for HIV or AIDS?☐YES NO☐
-
- **WOMEN :** Are you pregnant/nursing? YES☐NO☐ Taking Birth Control Pills: YES☐NO☐

I, being the patient or parent/guardian of the above minor patient, understand that the information contained in the medical history is important to my dental treatment. I certify that all the information I have completed is correct and I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other healthcare providers as is required by this dental office to perform diagnostic procedures as required to determine necessary treatment. I understand that the total payment of the dental services is my responsibility and not that of the insurance company.

_____ _____ _____
Signature of Patient (Parent/Guardian) Date Staff Initial

Please read & sign PRIVACY ACT on next page……..

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.

In this office, **Kawartha Endodontics** 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.

Included in 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 Dr. Kilislian or any member of our team.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality dental care and have signed confidentiality agreements.

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 ensure continuous high quality service
- to assess your dental needs and provide dental care
- to advise you of treatment options
- to enable us to contact you and establish and maintain communications with you
- to offer and provide treatment, care and services in relationship to specialty Endodontics/Sedation
- 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 endodontic information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching, demonstrating and research on an anonymous basis both in the office and through publications
- to complete and submit dental claims for third party adjudication and payment.

PLEASE READ OTHER SIDE, SIGNATURE REQUIRED ===>

- to comply with agreements/undertaking 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 deliver your charts and records to the dentists 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 Boards (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid account
- to assist the 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 personal information for the purposes listed. 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 Professionals Act (RHPA)* for the purpose of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA and for the defense 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 a 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 of 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 Kawartha Endodontics can collect, use and disclose personal information as set out above in the information about the offices privacy policies.

_____ _____

Patient/Guardian Signature Print Name

_____ _____

Date Signature of Witness