DENTAL by HIGHPARK

PATIENT REGISTRATION

First Name: _____Middle Name: _____ Last Name: _____
Preferred Name: _____ Birth Date: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home phone: _____Cellular: _____Work phone: _____
Occupation: _____ Marital Status: _____Emergency #:_____
Email: _____
How did you hear about us? _____

MEDICAL HISTORY

Are you under a physician's care? _____
Have you ever been hospitalized? _____
Have you ever had a serious head or neck injury? _____
List any medications you are taking: _____
Are you on a special diet?_____
Do you use tobacco, controlled substances? If yes, details? _____
Are you pregnant? _____ Take birth control pills? _____ Nursing? _____

Are you allergic to any of the following? (please circle)
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
Other Allergy: _____

Do you have or have had any of the following? (please circle)

HIV/AIDS
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Artificial Heart Valve
Arthritis /Gout
Artificial Joint
Asthma
Back Problems
Blood Disease
Blood Transfusion
Breathing problems
Cancer
Chemotherapy
Chest Pain
Cold sores
Convulsions
Diabetes Type 1/2
Drug Addiction/Alcohol
Dry Mouth
Easily Winded
Emphysema
Excessive Thirst
Epilepsy or Seizures
Excessive Bleeding
Fainting/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Glaucoma
Hay fever
Heart Attack/ Failure
Heart Disease
Heart Murmur
Heart Pacemaker
Heart Trouble
Hemophilia
Hepatitis Type_____
Herpes
High blood pressure
Hives or Rash
Hypoglycemia
Intestinal Disease
Jaw Pain
Kidney Problems
Leukemia
Liver Disease
Low blood pressure
Lung Disease
Mitral Valve Prolapse
Pain in jaw joints
Parathyroid Disease
Psychiatric Care
Radiation Treatments
Renal Dialysis
Respiratory Disease
Rheumatic fever
Rheumatism
Scarlet fever
Shingles
Spina Bifida
Sickle Cell Disease
Sinus trouble
Sleep Apnea
Stroke
Swelling of limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcer
Yellow Jaundice

DENTAL HISTORY

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1 What is the reason for your visit today? Are you currently experiencing any dental problems?

_____

2 Have you been seeing a dentist regularly? If not, why not? Yes No

_____

3 Are you nervous during dental visits? Yes No Not Sure/Maybe

4 Have you had a bad experience or complications during dental treatment? Yes No Not Sure/Maybe

5 Have you had any dental surgery? Yes (explain) No

_____

6 When was your last dental visit? What was done at that appointment?

_____

7 When was your last dental cleaning? _____

8 When did you last have dental x-rays?

_____

9 Have you ever seen a dental specialist? Yes No Not Sure/Maybe

10 How often do you brush your teeth? How often do you floss? Do your gums bleed when you brush or floss?

_____

11 Have you been told to take antibiotics before a dental appointment? Yes No Not Sure/Maybe

12 Do you feel that you have bad breath? Yes No Not Sure/Maybe

13 Are you happy with the appearance of your teeth? Yes No Not Sure/Maybe

14 How anxious are you to keep your natural teeth?

14 Do you have any problems with your jaw (clicking, limited movement, pain)? Yes No Not Sure/Maybe

15 Have you ever had an injury to the teeth or jaws or been involved in a motor vehicle accident?

Yes No Not Sure/Maybe

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature _____ Date: _____

CONSENT FORM

Privacy of your personal health information is an important part of our clinic providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly.

Dental by Highpark will ensure that:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal health 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

Dental by Highpark is using and disclosing your information:

- To deliver safe and efficient patient care and to ensure continuous high-quality service
- To assess your health needs and advise you of treatment options
- To enable us to contact you regarding your appointments, follow up treatment, care, billing, outstanding
- 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 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 to 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 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 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 (HPARB)
- To assist this office to comply with all regulatory requirements
- To comply generally with the law

By signing the consent form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal health information for the purpose that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.

I _____ give my consent that the dental office can collect, use and disclose
(Patient Name)

personal health information as set out above.

Patient/Parent/Guardian Signature: _____ Date: _____

Dentist Signature _____ Date: _____

COVID-19 Screening Questionnaire

At Dental by Highpark, the health and safety of our patients and staff has always been our top priority. To ensure we are providing the safest environment possible to deliver dental care, we kindly ask you to please complete this brief questionnaire prior to your appointment. The has been mandated by the Royal College of Dental Surgeons of Ontario for everyone's safety. We appreciate your help and understanding with this measure.

Patient Name: _____

Screening Questions	Pre-Screen		In-Office	
Have you travelled outside of Canada in the past 14 days?	YES	NO	YES	NO
Have you tested positive to COVID-19 or had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?	YES	NO	YES	NO
Do you have any of the following symptoms: • Fever • New onset of cough • Worsening chronic cough • Shortness of breath • Difficulty breathing • Sore throat • Difficulty swallowing • Decrease or loss of sense of taste or smell • Chills • Headaches • Unexplained fatigue/malaise/muscle aches • Nausea/vomiting, diarrhea, abdominal pain • Pink eye • Runny nose/ nasal congestion without other know cause	YES	NO	YES	NO
If you are 70 years of age or older, are you experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	YES	NO	YES	NO

Any 'YES' response must be discussed with the managing dentist immediately.

When you arrive in the office:

- Only patients are allowed to come
- Wear a mask
- Sanitize your hands
- Have your temperature taken

DENTAL PATIENT SURVEY

(When answering each question, be as detailed as possible)

1. What dental problems cause people the most trouble?

2. What would you most want to achieve from dental care?

3. How would you describe the perfect Dentist? Be specific.

4. What key factors most influence you when choosing a Dentist?