DENTAL MEDICAL AND HISTORY UPDATE

To ensure the highest quality of healthcare, we ask that you complete this patient update form.

Patient Name: _____ **Date of Birth:** _____

CONTACT INFORMATION

Phone Number (Home): _____ **Cell:** _____

Address: _____

PREFERED METHOD OF CONTACT (Select all that apply. Any changes to contact information, update below).

☐ **Phone call** ☐ **Email** ☐ **Text message**

Email address: _____ **Cell:** _____

Any changes in insurance? **YES** ☐ **NO** ☐
EXPLAIN: _____

Any change in health since last dental visit? **YES** ☐ **NO** ☐
EXPLAIN: _____

Any surgeries or hospitalizations since last dental visit? **YES** ☐ **NO** ☐
EXPLAIN: _____

Are you being treated for any medical condition at present? **YES** ☐ **NO** ☐
EXPLAIN: _____

Any new family history of cancer or other serious health issues? **YES** ☐ **NO** ☐
EXPLAIN: _____

Are you taking blood thinners or diagnosed with a bleeding disorder? **YES** ☐ **NO** ☐
EXPLAIN: _____

Are you a diabetic? **YES** ☐ **NO** ☐
EXPLAIN: _____

Are you taking any medications or supplements (prescription and/or non-prescription)? **YES** ☐ **NO** ☐
EXPLAIN: _____

Have you discovered you are allergic to medications, foods, or latex? **YES** ☐ **NO** ☐
EXPLAIN: _____

Females only: Are you pregnant? **YES** ☐ **NO** ☐

I Certify that I have read, and I understand the questions above. I acknowledge that my questions, if any, about the inquiries above have been answered to my satisfaction. I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Patient Signature **Date**

_____ _____
DDS/Hygiene Signature **Date**

CONSENT
COLLECTION OF PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality dental care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly. We collect personal information for the following purposes and mandate:

- **Only necessary information is collected about you;**
- **We only collect, use, and share your information with your consent;**
- **Storage, retention and destruction of your personal information complies with existing legislation;**
- **We continuously review our policies and privacy protection protocols on an ongoing, annual basis to ensure that we comply with our obligations under various provincial legislation;**
- **We confirm that our privacy protocols comply with provincial privacy legislation and standards of our provincial regulatory body, as amended from time to time.**

<u>This office will collect, use and disclose information about you for the following purposes, including:</u>

- **To deliver safe and efficient patient care and to identify and to ensure continuous high-quality service.**
- **To assess your health and dental care needs and to advise you of treatment options**
- **To enable us to contact you and to establish and maintain communication with you.**
- **To communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists.**
- **To maintain communication with you to provide health care information and to book/confirm appointments.**
- **To allow us to efficiently follow-up for treatment, care and billing.**
- **To comply with legal and regulatory requirements, including the delivery of patients' charts and records to our provincial regulatory body, in a timely fashion.**
- **To invoice for goods and services and to process credit card payments.**
- **To comply with our obligations under applicable federal and provincial privacy legislation.**

By signing the consent section of this Patient Consent Form below, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes included herein. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Our office will not, under any conditions, supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly for your review, and for your specific consent. I have reviewed the above information that explains how your office will use and protect my personal information. I understand that I may withdraw my consent at any time, and, should I wish to do so, I will contact the clinic to inform them of this intention. I agree that my dental clinic or dental care provider, as outlined herein, can collect, use and disclose personal information for the purposes set out herein.

_____ _____

Date **Print Name**

_____

Signature

PATIENT ACKNOWLEDGEMENTS
CANCELLATION POLICY

It is the practice of our office to see all our patients on an appointment basis. We respect your time and make every effort to remain on schedule. We ask that you extend the same courtesy to us. If you are unable to keep your appointment, we request that you notify us at least <u>2 business days</u> prior to your appointment. When you do so, we are able to offer your timeslot to another patient. Patients who fail to provide us with adequate notification time will be charged a missed appointment fee of $50.00.

If you have any questions or require clarification, please contact our office.

I have read and understood the Cancellation Policy as outlined herein. I agree to the terms described and assume full liability for any fees charged should I fail to abide by these short notice requirements.

_____

Date

_____

Signature