



AUTHORIZATION FOR RELEASE OF DENTAL/MEDICAL RECORDS AND RADIOGRAPHS

Current/Previous Dentist:

This note authorizes the transfer of my (and listed family members) dental/medical records to the office of:

2032 Dentistry
Dr. Kathryn Moore
Dr. Sarah Trotter
Email: info@2032Dentistry.com
Fax: 705 743-5680

| Patients Names | Signatures (ages 16 and over) |
|----------------|-------------------------------|
| 1 | |
| 2 | |
| | |
| | |
| _ | |
| 6 | |
| | |
| Address: | |
| Street: | City: |
| Postal Code: | Province: |
| Phone Number: | |
| | |



| | | PERSONAI | L INFO | RMATION | | | | | |
|---|------------------------------------|---|----------------------------|--------------------------------|-------------|-----------------|---------|------------|--------|
| PATIENT'SLASTNAME | | FIRST | | MIDDLE | | DATE OF BIF | RTH | SE | Х |
| | | | | | | / / | | М | F |
| HOME PHONE | WORK PHONE | | MOBILE | | | M D | Y | | |
| | | | | | | | | | |
| PATIENT'S MAILING ADDRESS | | CITY | | | | PROV. | POSTA | AL CODE | |
| | | | | | | | | | |
| E-MAILADDRESS | | | | | | | | | |
| Preferred Contact Method (please HomePhone Work | check) «Phone MobileF | Phone Mobile To | ext | Email | | | | | |
| PERSON RESPONSIBLE FOR ACCOU | NT | | | RELATIONSHIP | DA | TE OF BIRTH | | | |
| | | | | | / | / | | | |
| | | | | | M | D | Υ | | |
| PATIENT'S GUARDIAN IF UNDER 18 | i | | | PATIENT/GUARDIAN'S EMPLOYER | S W | ORK PHONE | | | |
| PATIENT OR GUARDIAN'S SPOUSE | | | | EMPLOYER | W | ORK PHONE | | | |
| PERSON W | VE CAN CONTACT | I Γ IN CASE OF AN EMERG | GENCY (OTI | IER THAN YOUR FAMILY | (HOME) | | | | |
| NAI | ME | | | PHONE | | ALTERN | IATE PH | HONE | |
| | IF THIS IS YOUR | FIRST VISIT, HOW DID | YOU HEAR | ABOUT OUR OFFICE? | - | | | - | |
| Referred by another person: | | | | Other: | | | | | |
| · | | | | | | | | | ı |
| DO YOU HAVE [| DENTAL INSURAN | NCE COVERAGE?If yes, F | Please prov | ide our reception staff v | with your l | benefits inform | nation | | |
| Primary Coverage Insurer: | Seco | ondary Coverage Insure | r | Т | ertiary Co | verage Insurer | | | |
| | · | | - > | _ | | | | | |
| | | | AYMEN' POLICY | Т | | | | | |
| | | • | POLICI | | | | | | |
| Dental plans in the marketplace may or may not cover the full e on factors which may not have b not covered through your denta | extent of the co been considere | osts you incur for you d by your insurance o | r dental tr carrier. Fu | eatment. This can occ | cur becau | use the fees i | n our c | office are | based |
| PLEASE REVIEW YOUR DENTAL P | PLAN CAREFULI | Y TO ENSURE YOU U | NDERSTAI | ND THE EXCLUSIONS A | AND LIM | ITATIONS OF | YOUR | PLAN | |
| Payment for dental services is e so that you may make payment | | | | | | | | | |
| I am financially responsible for | any balances d | lue and authorize the | e dentists | to release any inforn | nation fo | r any claim | | | |
| I certify that I have read or had realize the risks and limitations | | e contents of this for | m, filled ii | n completely and acc | urately t | o the best of | my kn | owledge | and do |
| Patient/GuardianSigna | <mark>ture</mark> | | | | Date | | | | |



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 bylaw.

We collect information from our patients such as names,home addresses, home and/or work telephone numbers, and emailaddresses(collectivelyreferredtoas"ContactInformation").

Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients and/or legal guardians or persons financially responsible for patient accounts, for dental services, to process credit card payments, or to collect unpaid accounts.
- To process claims for payment or reimbursement from third---party benefit providers, insurance companies and government agencies.
- To send reminders to patients concerning the need for further dental examinationor treatment.
- To send patients informational material about our dental practice.

Contact 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 the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services from whoever has been written as financially responsible for the account.

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 dentaltreatment.

Patients' Medical Information is disclosed:

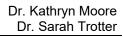
- To all third-party benefit providers, insurance companies and government agencies where a claim is being submitted for reimbursement or payment of all or part of the cost of dentaltreatment.
- To other dentists and dental specialists, where further information and/or discussion is required.
- To other dentists and dental specialists if the patient has been referred by us to the other dentist of dental specialist for treatment.
- To other health care professionals such as physicians if the patient has been referred by us to the other health care professional for either a second opinion or treatment.
- Where we are seeking and/or providing information to the following: laboratories, radiology centres, hospitals, etc.
- To include the following when necessary, such as: videos, pictures, slides, etc., for educational purposes.

If we are ever considering selling all or part of our dental 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 the prospective purchaser safeguards all personal information.

Dentists are regulated by the Royal College of Dental Surgeons of Ontario which may inspect our records and interview our staff as part of its regulatory activities in the public interests.

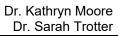
I consent to the collection, use and disclosure of my personal information as set outabove.

| Patient/GuardianSignature | Da | <mark>te</mark> |
|---------------------------|----|-----------------|
| | | |





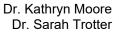
| Child's Full Name: | Nickname: | Date of birth: _ | _// | |
|--|---|--|---|--|
| Gender: M_ F_Race/Ethnicity: | | | | |
| Date of last physical examination: | | | | |
| Name/address/phone of primary phy | | | | |
| Name/address/phone of medical spe | ecialists: | | | |
| Is your child being treated by a physi Is your child taking any medication, (| | | | NO_ |
| dietary supplements? List name, dose | | | | NO_ |
| Has your child ever been hospitalized | d, had surgery or a sigi | nificant injury, or bee | en treated | |
| in an emergency department? List da | | | | NO_ |
| | | | | |
| Has your child ever had a reaction to Describe | | | YES | NO_ |
| Has your child ever had a reaction or | allergy to an antibioti | | | |
| medication? List | | | YES | NO_ |
| Is your child allergic to latex or anyth | ing else such as metal | s. acrylic. or dye? Lis | t: | |
| | | | YES | NO_ |
| Is your child up to date on immunizat | tions against childhoo | d diseases? | YES | NO_ |
| • | G | | ovide | |
| Please mark YES if your child has a history details in the box at the bottom of this list to your child. Complications before or during birth, | y of the following condit t. Mark NO after each line , prematurity, birth de | ions. For each "YES", pree if noneof those conditions | ions applies inherited | |
| Please mark YES if your child has a history details in the box at the bottom of this list to your child. Complications before or during birth, conditions | y of the following condit t. Mark NO after each line , prematurity, birth de | ions. For each "YES", proce if noneof those conditions or | ions applies inherited YES | |
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| Impaired vision, hearing, or speech | | YES NO |
|--|---|--------|
| Developmental disorders, learning prol | olems/delays, or intellectual | YES NO |
| Cerebral palsy, brain injury, epilepsy, o | r convulsions/seizures | YES NO |
| Autism/autism spectrum disorder | | YES NO |
| , , | aines, fainting, or dizziness | YES NO |
| Hydrocephaly or placement of a shunt (| • | |
| | | |
| , , , , | r (ADD/ADHD) | |
| | or psychiatric problems/treatment | |
| | nal, or sexual) or neglect | |
| | nia | |
| Precocious puberty or hormonal proble | ems | YES NO |
| | | |
| | od disorder | |
| | re bleeding | |
| <u> </u> | ets | |
| | otherapy, radiation therapy, or bone marr | |
| • | | |
| | et fever, cytomegalovirus (CMV), methicil | |
| 2 7 | a),sexually transmitted disease (STD), or h | |
| immunodeficiency virus (HIV)/AIDS | | YES NO |
| PROVIDE DETAILS HERE (for any ques | tion answered YES): | |
| • | istory pertaining to this child or his/her fa | 2 |
| What is your primary concern about yo | ur child's oral health? | |
| How would you describe: your child's oral health? your oral health? the oral health of your other children? | Excellent_ Good_ Fair_ Poor_ Excellent_ Good_ Fair_ Poor_ Excellent_ Good_ Fair_ Poor_ Not appl | icable |
| 5 5 | | YES NO |
| If yes, indicate all that apply: | Mother Father Brother Sister | |

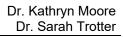
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Does your child have a history of any of the following? For each YES response, please describe:

| Inherited dental characteristics. Describe | _ YES_ | _ NO |
|--|--------|------|
| Mouth sores or fever blisters. Describe | _ YES_ | _NO |
| Bad breath . Describe | | |
| Bleeding gums. Describe | | |
| Cavities/decayed teeth. Describe | _ YES_ | _NO |
| Toothache. Describe | | |
| Injury to teeth, mouth or jaws. Describe | _ YES_ | _NO |
| Clinching/grinding his/her teeth. Describe | | |
| Jaw joint problems (popping, etc.). Describe | | |
| Excessive gagging. Describe | | |
| Sucking habit after one year of age. Describe | YES_ | _NO |
| If yes, which: Finger_ Thumb_ Pacifier_ Other_ How long? | | |
| How often does your child brush their teeth? times per | | |
| Does someone help your child brush? | YES_ | _NO |
| How often does your child floss his/her teeth? Never Occasionally Daily Does someone help your child floss? | YES_ | _NO |
| What type of toothbrush does your child use? Hard_ Medium_ Soft_ Unsure_ What toothpaste does your child use? | | |
| What is the source of your home drinking water? | | |
| City/community supply Private well Bottled | | |
| Do you use a water filter at home? | YES | NO |
| If YES, type of filtering system: | _ | |
| Please check all sources of fluoride your child receives: Drinking water Toothpaste Over-the-counter rinseFluoride treatment in the der office | ıtal | |
| Prescription rinse/gel drops/ tablets/ vitamins | | |
| Fluoride varnish by pediatrician/other practitioner_ Other: | _ | |
| Does your child regularly eat 3 meals each day | YES | NO |
| Is your child on a special or restricted diet? Describe: | | NO_ |
| Is your child a 'picky eater'? Describe: | | NO_ |
| Does your child have a diet high in sugars or starches? Describe: | | |
| Do you have concerns regarding your child's weight? Describe: | | _NO |





| How frequently does you | r child have the following? | | | | |
|--|--|-------------|-------|--|--|
| Candy or other sweets: | Rarely_ 1-2 times/day_ 3 or more times/day_ Product | | | | |
| Chewing gum: | Rarely_ 1-2 times/day_ 3 or more times/day_ Type | | | | |
| Snacks between meal: | Rarely_ 1-2 times/day_ 3 or more times/day_ Usual snack | | | | |
| Soft drinks*: | Rarely_ 1-2 times/day_ 3 or more times/day_ Product | | | | |
| (* such as juice, fruit-flav | (* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened | | | | |
| beverages, sports drinks, | | | | | |
| Please note other signific | ant dietary habits: | | | | |
| Does your child participa | te in any sports or similar activities? | | | | |
| | | YES | NO | | |
| 2 00 01 10 01 | | | _ 1.0 | | |
| Does your child wear a mouthguard during these activities? | | | NO | | |
| - | ined or treated by another dentist? | | | | |
| | sit: Date of last visit: | | | | |
| | t visit: | | | | |
| Were x-rays taken of the | teeth or jaws? | YES_ | NO_ | | |
| | ıl x-rays: | | | | |
| | rthodontic treatment (braces, spacers, or other appliances | s)?YES_ | NO_ | | |
| If YES, when? | | | | | |
| Has your child ever had a | difficult dental appointment? | YES_ | _NO_ | | |
| If YES, describe: | | | | | |
| How do you expect your | child will respond to dental treatment? | | | | |
| | omewhat poorly Very poorly | | | | |
| Is there anything else we If YES, describe: | should know before treating your child? | YES_ | _NO_ | | |
| | | | | | |
| Signature of parent/guar | dian Relationship to child Date | | | | |
| Signature of staff member | reviewing history | | | | |