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. ____________________	____________________
3. ____________________	____________________
4. ____________________	____________________
5. ____________________	____________________
6. ____________________	____________________

Address:

Street: ______________________ City: ______________________

Postal Code: ______________________ Province: ______________________

Phone Number: ______________________ Email: ______________________

____

20|32 twenty thirty two DENTISTRY FOR LIFE

Dr. Kathryn Moore
Dr. Sarah Trotter

PERSONAL INFORMATION

PATIENT'SLASTNAME		FIRST	MIDDLE	DATE OF BIRTH / / M D Y	SEX M F
HOME PHONE	WORK PHONE		MOBILE		
PATIENT'S MAILING ADDRESS		CITY		PROV.	POSTAL CODE
E-MAILADDRESS					
Preferred Contact Method (please check) HomePhone WorkPhone MobilePhone Mobile Text Email					
PERSON RESPONSIBLE FOR ACCOUNT			RELATIONSHIP	DATE OF BIRTH / / M D Y	
PATIENT'S GUARDIAN IF UNDER 18			PATIENT/GUARDIAN'S EMPLOYER	WORK PHONE	
PATIENT OR GUARDIAN'S SPOUSE			EMPLOYER	WORK PHONE	

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)		
NAME	PHONE	ALTERNATE PHONE

IF THIS IS YOUR FIRST VISIT, HOW DID YOU HEAR ABOUT OUR OFFICE?	
Referred by another person:	Other:

DO YOU HAVE DENTAL INSURANCE COVERAGE?If yes, Please provide our reception staff with your benefits information		
Primary Coverage Insurer:	Secondary Coverage Insurer	Tertiary Coverage Insurer

PAYMENT POLICY

Dental plans in the marketplace today are too numerous and varied to allow us to know the details of all of them. Your particular dental plan may or may not cover the full extent of the costs you incur for your dental treatment. This can occur because the fees in our office are based on factors which may not have been considered by your insurance carrier. Furthermore, there may be certain procedures performed which are not covered through your dental plan. These factors are beyond ourcontrol.

PLEASE REVIEW YOUR DENTAL PLAN CAREFULLY TO ENSURE YOU UNDERSTAND THE EXCLUSIONS AND LIMITATIONS OF YOUR PLAN

Payment for dental services is expected when treatment is rendered. You will be informed of your amount at the time treatment is completed so that you may make payment at that visit. A 2% service charge will be applied to all account balances outstanding for more than 30days.

I am financially responsible for any balances due and authorize the dentists to release any information for any claim

I certify that I have read or had read to me the contents of this form, filled in completely and accurately to the best of my knowledge and do realize the risks and limitations involved.

Patient/GuardianSignature **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 e-mailaddresses(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____**Date**______________________

Child's Full Name: ________________________ Nickname:__________ Date of birth: __/__/____
Gender: M__ F__Race/Ethnicity: ______________ Height: __________Weight: ______________
Date of last physical examination: _______________________________
Name/address/phone of primary physician: ____
Name/address/phone of medical specialists: ____

Is your child being treated by a physicianat this time? Reason _________________________ YES__ NO__
Is your child taking any medication, (prescription or over the counter), vitamins, or dietary supplements? List name, dose, frequency & date started: ______________________ YES__ NO__
____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? List date & describe: ______________________________ YES__ NO__
____

Has your child ever had a reaction to or problem with an anesthetic?
Describe ____ YES__ NO__
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List ____ YES__ NO__
____

Is your child allergic to latex or anything else such as metals, acrylic, or dye? List:
____ YES__ NO__
Is your child up to date on immunizations against childhood diseases?........................YES__ NO__

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if noneof those conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions..YES__ NO__
Problems with physical growth or development ....YES__ NO__
Sinusitis, chronic adenoid/tonsil infections ....YES__ NO__
Sleep apnea/snoring, mouth breathing, or excessive ....YES__ NO__
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ....YES__ NO__
Irregular heart beat or high blood ....YES__ NO__
Asthma, reactive airway disease, wheezing, or breathing ....YES__ NO__
Cystic fibrosis ....YES__ NO__
Frequent colds or coughs, or pneumonia ....YES__ NO__
Frequent exposure to tobacco smoke ....YES__ NO__
Jaundice, hepatitis, or liver problems ....YES__ NO__
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ......YES__ NO__
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ....YES__ NO__
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating ....YES__ NO__
Bladder or kidney problems ....YES__ NO__
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems ....YES__ NO__
Rash/hives, eczema or skin problems ....YES__ NO__

Continued on next page...

Impaired vision, hearing, or speech .... YES__ NO__
Developmental disorders, learning problems/delays, or intellectual .... YES__ NO__
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures .... YES__ NO__
Autism/autism spectrum disorder .... YES__ NO__
Recurrent or frequent headaches/migraines, fainting, or dizziness .... YES__ NO__
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) .... YES__ NO__
Attention deficit/hyperactivity disorder (ADD/ADHD) .... YES__ NO__
Behavioral, emotional, communication, or psychiatric problems/treatment .... YES__ NO__
Abuse (physical, psychological, emotional, or sexual) or neglect .... YES__ NO__
Diabetes, hyperglycemia, or hypoglycemia .... YES__ NO__
Precocious puberty or hormonal problems .... YES__ NO__
Thyroid or pituitary problems .... YES__ NO__
Anemia, sickle cell disease/trait, or blood disorder .... YES__ NO__
Hemophilia, bruising easily, or excessive bleeding .... YES__ NO__
Transfusions or receiving blood products .... YES__ NO__
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant....... YES__ NO__
Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA),sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS .... YES__ NO__

PROVIDE DETAILS HERE (for any question answered YES):

____

____

____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? .... YES__ NO__
If YES, describe ____

____

What is your primary concern about your child's oral health?

____

How would you describe:
your child's oral health? Excellent__ Good__ Fair__ Poor__
your oral health? Excellent__ Good__ Fair__ Poor__
the oral health of your other children? Excellent__ Good__ Fair__ Poor__ Not applicable__
Is there a family history of cavities? .... YES__ NO__
If yes, indicate all that apply: Mother__ Father__ Brother__ Sister__

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201-A George Street North,
Peterborough, ON K9J 3G7
705 743-5924 : Fax: 705 743-5080
info@2032Dentistry.com

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 ______________________________ YES__NO__
Bleeding gums. Describe ______________________________ YES__NO__
Cavities/decayed teeth. Describe ______________________________ YES__NO__
Toothache. Describe ______________________________ YES__NO__
Injury to teeth, mouth or jaws. Describe ______________________________ YES__NO__
Clinching/grinding his/her teeth. Describe ______________________________ YES__NO__
Jaw joint problems (popping, etc.). Describe ______________________________ YES__NO__
Excessive gagging. Describe ______________________________ YES__NO__
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 rinse__Fluoride treatment in the dental office__
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:______________________________ YES__ NO__
Is your child a 'picky eater'? Describe:______________________________ YES__ NO__
Does your child have a diet high in sugars or starches? Describe:____________________ YES__ NO__
Do you have concerns regarding your child's weight? Describe:____________________ YES__ NO__

How frequently does your 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-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits:____
____

Does your child participate in any sports or similar activities?
Describe:____ YES__ NO__
____
Does your child wear a mouthguard during these activities? .... YES__ NO__
Has your child been examined or treated by another dentist? .... YES__ NO__
If YES: Date of first visit: ____________ Date of last visit: _________________
Reason for last visit:________
Were x-rays taken of the teeth or jaws? .... YES__ NO__
Date of most recent dental x-rays: _____________________
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? .. 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?
Very well__Fairly well__ Somewhat poorly__ Very poorly__
Is there anything else we should know before treating your child? .... YES__ NO__
If YES, describe:
____
____
____

Signature of parent/guardian________________________ Relationship to child
_________________________ Date________________

Signature of staff member reviewing history_______________________________

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