dr.gaik orthodontics
children & adults

DATE:_____

NAME:_____

ADDRESS:_____**CITY:**_____**POSTAL CODE:**_____

BIRTHDATE: Month _____ **Day** _____ **Year** _____

Home Phone Number: _____ **Cell Phone Number:** _____
(These numbers are important for confirming your appointments and in the case of an emergency. Please keep updated)

E-mail contact _____

Mother's name:_____ **Father's name:**_____

Legal Guardians (if different): _____

Dentist:_____**Doctor:**_____
Date of last dental check-up: _____
Please complete the entire form. Dr. Gaik will review the questions and explain any that you do not understand.

MEDICAL HISTORY

List all allergies (medications / latex / metals / foods / other):_____
List all medications or supplements being taken (dosage): _____

Y N Has there been trauma to the head, neck or jaw? Please explain_____
Y N Is the patient's jaw painful? Does it click? Is there limited movement? _____
Y N (Circle) Does the patient smoke cigarettes / ecigarettes / use tobacco products
Y N (Circle) Is the patient pregnant? Due date: _____**Breastfeeding** _____
Y N Have the patient's tonsils and adenoids been removed? When_____
Y N Does the patient use cannabis? Type/Amount _____
Y N Is the patient in good health? Date of last medical check-up: _____
Please list hospitalizations/ surgeries _____

CIRCLE IF THE PATIENT HAS HAD ANY OF THE FOLLOWING:

Arthritis / Anemia / Asthma / Angina / ADHD / Artifical joint
Bleeding Disorder / Birth Defect / Blood pressure problems
Chest Pain / Cancer / Chemotherapy/Radiotherapy
Dizziness / Diabetes / Digestive Disorders / Drug Dependence
Epilepsy (Seizures) / Eating Disorders
Headaches / Hearing disorder / High blood pressure / Heart attack / Heart valve repair/replacement
Heart murmur (Do you require prophylactic antibiotics for dental work?
Hepatitis A / Hepatitis B / Hepatitis C / Liver Disease
HIV / AIDS
Jaundice / Kidney Disease / Leukemia
Lung Disease / Mitral valve prolapse
Nasal/Sinus Problems / Nervous disorders / Osteoporosis (medications)/ Pacemaker
Rheumatic Fever / Scarlet Fever / Staph or Strep Infections / Stroke / Sensory Concerns / Shortness of Breath
Tonsillitis / Tuberculosis (status _____**) / Thyroid Disease / TIA**
Ulcers/ Visual Disorders
Are there any other conditions/diseases that are not listed above. Please explain _____
Do you identify as a patient with a disability? _____

THE ABOVE MEDICAL HISTORY IS CORRECT AND COMPLETE :Please sign _____
All information is strictly private and protected by doctor-patient confidentiality.
EMERGENCY CONTACT PERSON (relation?)_____ **Contact #** _____
Y N Do we have permission to release information to your dentist?
Y N Do you have any orthodontic insurance coverage?

PRIVACY LEGISLATION

PATIENT CONSENT - 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. It is important to us to provide this service to our patients.

In this office **DR. NATALIE GAIK, ORTHODONTIST** 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.

Attached to this consent form, we have outlined what our office is doing to ensure that:

1. Only necessary information is collected about you
2. We only share your information with your consent
3. Storage, retention and destruction of your personal information complies with existing legislation
4. Privacy protocols comply with privacy legislation, regulatory body standards (RCDSO) and the law

Do not hesitate to discuss our policies with me or any member of our office staff.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

This office will collect, use and disclose information about you for the following purposes:

1. To deliver safe and efficient patient care
2. To identify and to ensure continuous high quality service
3. To assess your health needs
4. To provide health care
5. To advise you of treatment options
6. To enable us to contact you
7. To establish and maintain communication with you
8. To offer and provide treatment, care and services in relation to the oral and maxillofacial complex
9. To communicate with other treating health care providers (specialists ,general dentists)
10. To allow us to maintain communication and contact with you to distribute health care information and to book and confirm appointments
11. To allow us to efficiently follow up for treatment, care and billing
12. To complete and submit dental claims for third party adjudication and payment
13. To comply with legal and regulatory requirements, including the delivery of patients charts and records to the RCDSO in a timely fashion, when required, according to the RHPA
14. To comply with agreements/undertakings entered into voluntarily by the member with the RCDSO, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes.
15. To permit potential purchasers, practice brokers or advisors to evaluate the dental practice
16. To allow potential purchasers ,practice brokers or advisors to conduct an audit for practice sale
17. To deliver your charts/records to the dentists' insurance carrier to enable the insurance company to assess liability and quantify damages, if any
18. To prepare materials for the Health Professions Appeal and Review Board
19. To invoice for goods and services and collect unpaid accounts
20. To process credit card payments
21. To assist this office to comply with all regulatory requirements
22. To comply generally with the law

By signing the consent section of this 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 that are listed. If a new purpose arises, we will seek your approval in advance. Your information may be accessed by regulatory authorities under the RHPA for the purposes 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 supply your insurer with your confidential medical history. In the event of this request, we will forward the information directly to you for review and for your specific consent. We will contact you with unusual requests and contact you for permission to release such information and advise you if such a release is inappropriate. You may withdraw your consent for disclosure of your personal information and we will explain the ramifications of that decision and the process.

PATIENT CONSENT – I have reviewed the 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 Dr Natalie Gaik can collect, use and disclose personal information about

_____as set out above on (date) _____.

Signature _____Witness _____.