

New Patient Exam

(age 0 - 18)

Please Complete

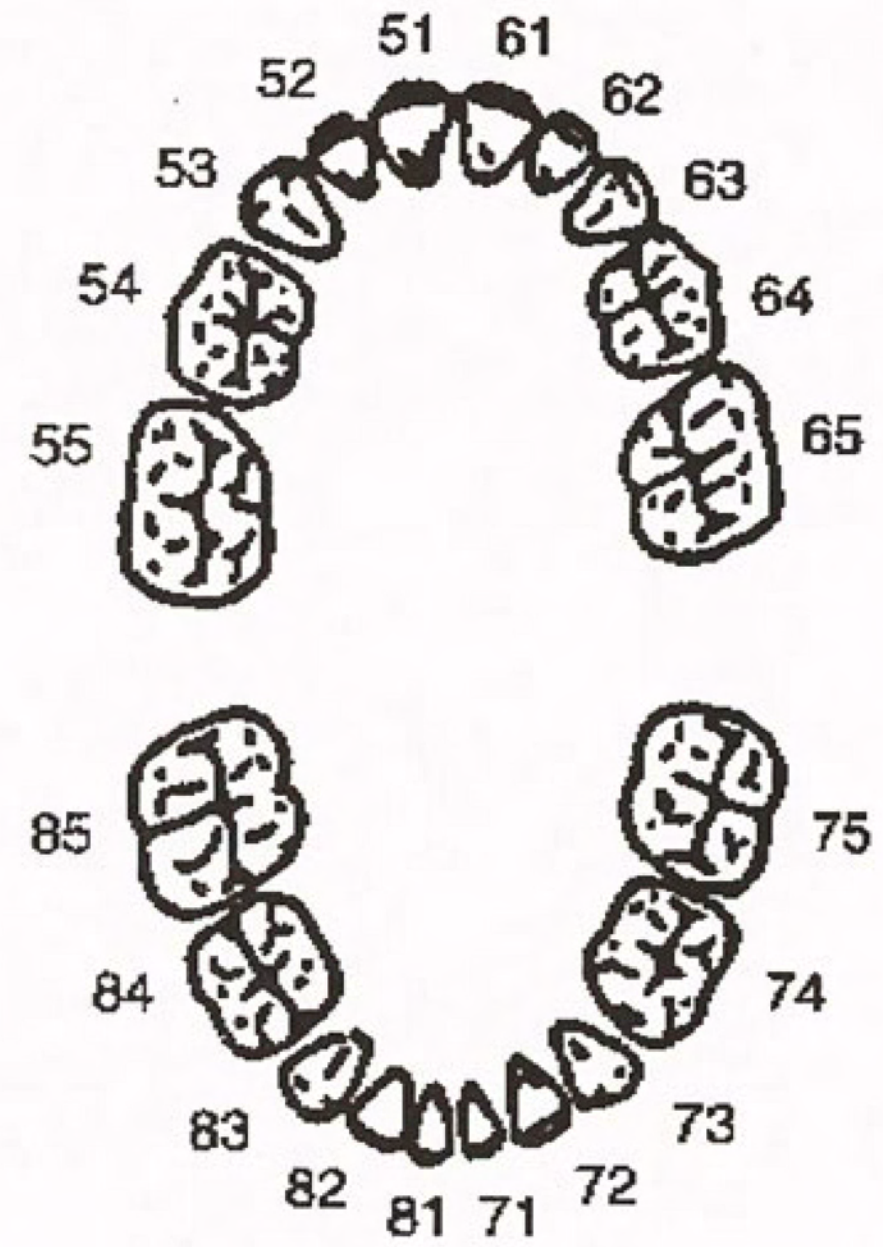
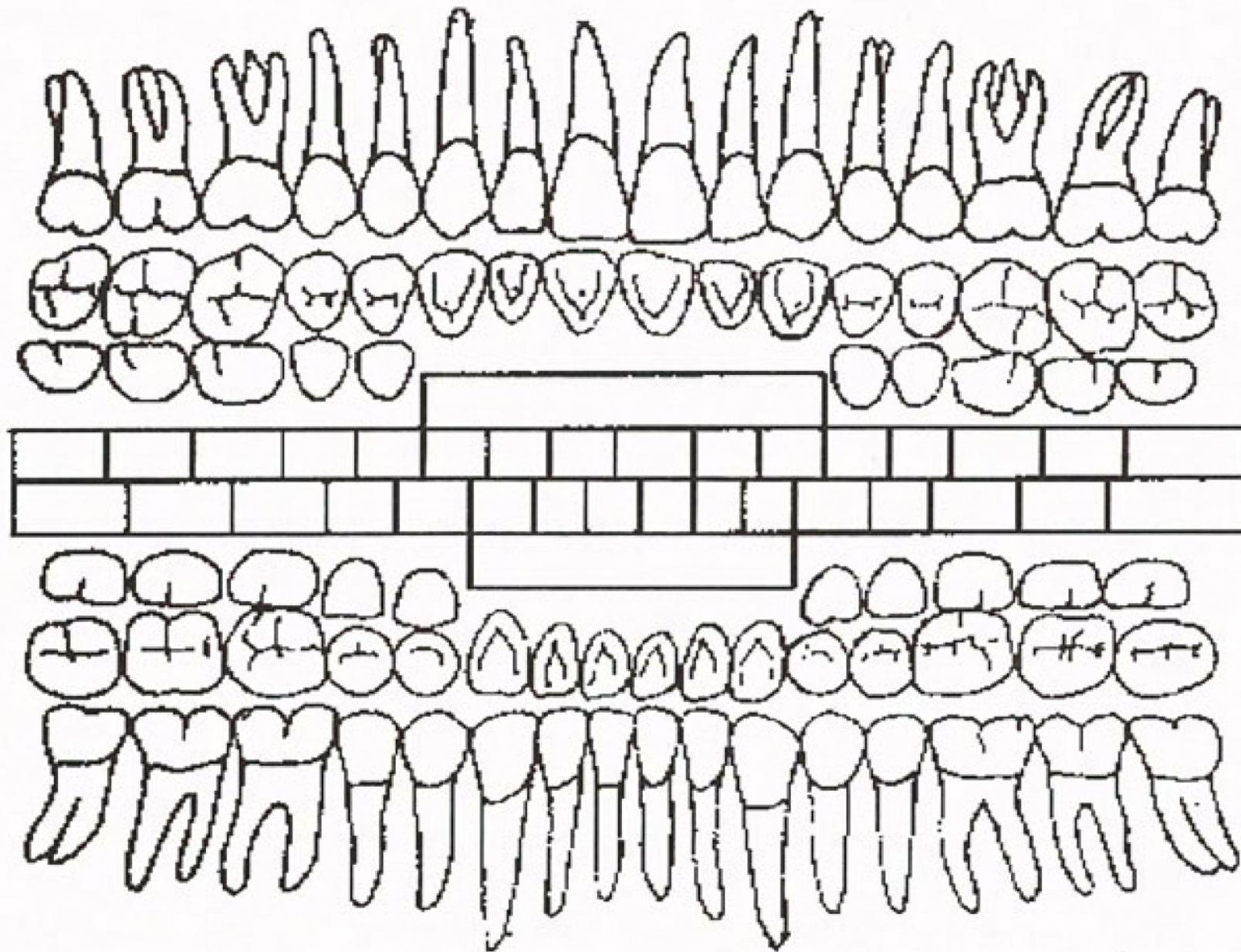
Name: _____ Parent's Name: _____

Address: _____

Phone: (H) _____ (B) _____

Date of Birth _____ Emergency Contact: _____

Whom may we thank for referring you? _____



Occlusion: Right _____ Left _____ (molar/canine)
crossbites _____
overjet _____ mm, overbite _____ %, openbite _____
midline _____

Any deviate tongue habit? (swallow pattern) _____

Is there any need for an ortho evaluation? _____

General Oral Hygiene _____

Abnormalities/Individualities _____

COMMENTS: _____

For Office Use Only

Medical History

CHECK THE FOLLOWING IF YOUR ANSWER IS 'YES'

1. Have you come to this office for the relief of pain? yes no
If yes, where is the pain? _____
2. Have you had the pain for more than 3 weeks? yes no
3. Please circle any item that you use often in mouth care.

hand toothbrush	electric toothbrush
dental floss	gum stimulators,
water spray	toothpicks, stimulents
rubber tip	other _____
4. How would you describe your general medical health?

good	fair	poor
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5. When was the date of your last medical exam?

6. Are you now being treated or have you been treated by a physician? yes no
7. Is there a history of diabetes in your family? yes no
8. Are you thirsty most of the time? yes no
9. Have you recently lost weight unintentionally (with good appetite). yes no
10. Have you had eye trouble recently? yes no
11. Do cuts or injuries take longer to heal now than they did previously? yes no
12. Does your mouth feel dry or do you have a burning sensation of your lips or tongue? yes no
13. Have you taken or been given injections of steroids such as cortisone? yes no
14. Have you ever had an unusual reaction to dental anesthesia? yes no
Date of last occurrence _____

Previous dental treatment: _____

Experiences: _____

Have you ever become sick from, shown an allergy to or been told not to take:

- _____ Antibiotic (penicillin, etc.)
- _____ Codeine
- _____ Novocaine or other dental anesthetics
- _____ Latex
- _____ Other drugs or meds _____
- _____ Nuts, red food dye

Are you now taking or using medicines for

- _____ Diabetes (pills or shots)
- _____ Nerves (tranquillizers)
- _____ Heart or blood pressure (digitalis, Nitroglycerine, reserpine)
- _____ Blood (liver or iron pills, etc.)
- _____ Stomach/Gastric trouble (ulcer or other)
- _____ Headaches
- _____ Arthritis or rheumatism
- _____ Allergy

Are you now

- _____ Smoking
- _____ Pregnant
- _____ On a prescribed diet
- _____ Using thyroid medication
- _____ Using hormones (including birth control pills)
- _____ Using anticoagulants
- _____ Using dilantin
- _____ Using other medications _____

Have you ever had any of the following:

- _____ Heart disease/heart murmur
- _____ Shortness of breath without exercise or when lying down
- _____ Swelling of the ankles or feet
- _____ Pain, pressure or tight feeling in the chest
- _____ Heart attack or heart surgery
- _____ Rheumatic fever
- _____ High blood pressure
- _____ Fainting spells, convulsions, epilepsy
- _____ Frequent headaches (2 or 3 a week)
- _____ Headaches when lying down
- _____ Nervous breakdown, psychotherapy
- _____ Lung trouble (TB, asthma, emphysema)
- _____ Hepatitis, liver disease, jaundice
- _____ Arthritis, sore joints
- _____ Diabetes
- _____ Excessive bleeding
- _____ Blood trouble, anemia, leukemia
- _____ VD (syphilis, gonorrhea)
- _____ X-ray, radium or cobalt treatments
- _____ Cancer
- _____ HIV
- _____ Joint replacement
- _____ Surgeries _____

Signature _____

Date of Birth _____

Family Doctor _____



Child Patient Consent Form

Our office understands the importance of protecting your personal information. This office will collect, use and disclose information about you for the following purposes:

- To assess your health needs, and advise you of treatment options.
- To provide safe and efficient patient care, and identify and ensure high quality service.
- To allow us to efficiently follow-up for treatment, care and billing.
- To enable us to contact and maintain communication with you to book and confirm appointments and to distribute health-care information.
- To communicate with other treating health-care providers, including other dentists.
- To offer and provide treatment, care and services in relationship to the oral and maxillofacial complex, and dental care generally.
- For teaching, marketing, research and demonstrating purposes, on an anonymous basis.
- To complete and submit dental claims for third party adjudication and payment.
- To comply with all legal and regulatory requirements.
- To deliver your charts and records to the dentist’s insurance carrier to enable the insurance company to assess liability and quantify damages, as necessary.
- To permit potential purchasers, practice brokers or advisors to evaluate the dental practice and/or conduct an audit in preparation for a practice sale.
- To invoice for goods and services, process credit card payments, and collect unpaid accounts.

By signing the consent section of this Patient Consent 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 above. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under terms of the Regulated Health Professions Act (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario, fulfilling its mandate under the RHPA, and for defense of a legal issue.

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 to you for review, and for your specific comment.

When unusual requests are received, we will contact you for permission to release such information. You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

I have reviewed the above information that explains how this office will use my personal information, and the steps they are taking to protect my information. I know that this office has a Privacy Code, and I may ask to see the Code at any time. Dr. Derek Grundy is the Privacy Information Officer in this office.

I agree that Grundy Family Dental care may collect, use, and disclose personal information about _____ as set out above in the information about the office’s privacy policies.

Print Patient Name _____

Parent(’s)/Guardian’s Signature _____ Print Parent/Guardian Name _____

Date _____ Signature of Witness _____