WELCOME

HarmonySmiles ORTHODONTICS

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

Patient Information

Date: _____

Name: _____ DOB: _____

Address: _____ Sex: ☐ M ☐ F

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Parent/Guardian name: _____

Who should we thank for referring you? _____Do you have dental insurance? _____

How did you hear about us? _____

Responsible Party Information

Name: _____ Spouse: _____

DOB: _____ Spouse's DOB: _____

Address (If different from above) _____

Employer: _____ Spouse's Employer: _____

Work Phone: _____ Spouse's Work Phone: _____

Dental History

Family Dentist: _____ Date of last Dental visit: _____

Have you seen an orthodontist/Pediatric Dentist before? _____ Name:_____

Indicate any history of: (Please check all that apply)

☐ Is there pain with chewing, yawning or wide opening?
☐ Have there been injuries to the face, or teeth?
☐ Have you been informed of missing or extra teeth?
☐ Speech/articulation problems
☐ Tonsils/adenoids removed
☐ Thumb/finger sucking
☐ Tongue/swallowing problems
☐ Have you/child ever had orthodontic treatment?

Medical History

Family Physician: _____ Date of last check up: _____

Are you currently under medical care? _____ If yes, explain: _____

Do you have any drug allergies? _____ If yes, explain: _____

Indicate any history of: (Please check all that apply)

☐ Latex allergy ☐ Epilepsy or seizures ☐ asthma ☐ Diabetes

☐ Nickel/metal allergy ☐ Rheumatic fever ☐ Heart problems/murmur ☐ Headaches

☐ Hereditary problems ☐ Anemia ☐ Hepatitis ☐ HIV Positive

☐ Prolonged bleeding ☐ other: _____

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 by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses ("Contact Information"). Contact Information is collected and used for:

- to open and update patient files
- to invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
- to process forms for patient reimbursement from 3rd-party health benefit providers & private insurance companies
- to send reminders to patients concerning the need for further dental and/or orthodontic examination or treatment
- to send patients informational material about our orthodontic practice.

Contact Information is disclosed to 3rd party health benefit providers and insurance companies where the patient/ parent has submitted a claim for reimbursement and has asked us to communicate directly with the 3rd party on the patient's behalf. Financial information may be collected in order to make arrangements for the payment of dental services.
We collect information from our patients about their *health history, their family health history, physical condition, and dental treatment history* ("Medical Information"). Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- to 3rd party health benefit providers and insurance companies where patient submitted a claim for reimbursement
- to other dentists/specialists, where we are seeking an opinion, and patient has consented to us obtaining opinion
- to other dentists/specialists if the patient, with their consent, referred to other dentist/specialist for treatment
- to other dentists/specialists where those dentists/specialists asked us, with patient consent, to provide a 2nd opinion
- to other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a 2nd opinion or treatment.

If we are 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 that the prospective purchaser safeguards all personal information. Dentists and dental specialists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest.
I consent to the collection, use and disclosure of my personal information as set out above.
I authorize Drs. Kassas, Saltaji and Al Fakir to perform a clinical examination and to obtain photographic and radiographic documentation.

Name _____ Signature: _____ Date: _____
(Patient/Parent/Guardian)