ADULT

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www.palladiumorthodontics.com

Thank You for considering us for your orthodontic care.
We promise to do our best to provide you with the finest care available.
If you have any questions, do not hesitate to call us.

Whom may we thank for referring you to our office? _____

ORTHODONTICS & DENTOFACIAL ORTHOPEDICS

Patient's Clinical History/Family Information

(please complete in ink)

Name_____ Age_____ Sex_____ Date of Birth_____/_____/_____
LAST FIRST M.I. DD MM YY

Address _____ Tel.# (_____)_____
STREET CITY POSTAL CODE

Employer _____ Occupation_____ Work Tel.# (_____)_____

Best Telephone Number To Call For Appointments (During Business Hours) _____

Best Cell Phone#_____Best E-mail_____

Marital Status:

◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Common Law

Spouse's Name_____
LAST FIRST M.I.

Employer _____ Occupation_____Work Tel.# (_____)_____

Do you have Orthodontic Insurance? ◯ Yes ◯ No

If responsible party is other than yourself, please give information: ☐ Not Applicable

Name_____ Relationship to Patient_____

Address _____ Tel.# (_____)_____

Does Responsible Party have Orthodontic Insurance? ◯ Yes ◯ No

MEDICAL HISTORY:

General Physician Name: _____

Have you had or do you have any of the following?

	YES	NO		YES	NO
Rheumatic Fever	○	○	Persistant Headaches	○	○
Heart Murmur	○	○	Neck Pains	○	○
High Blood Pressure	○	○	Nerve or Brain Disease	○	○
Heart Attack/Stroke	○	○	Migraine	○	○
Blood Vessel Disease	○	○	Epilepsy	○	○
Blood Disorder	○	○	Mental Health Problems	○	○
AIDS/HIV Infection	○	○	Bone Disorders	○	○
Hepatitis	○	○	Arthritis	○	○
Diabetes	○	○	Artificial Joints	○	○
Ulcers	○	○	Sleep Apnea	○	○
Herpes (Any Type)	○	○	Ear Disorder	○	○
Psoriasis	○	○	Sinus Infection	○	○
Cancer	○	○	Swollen Glands	○	○
Asthma	○	○	Allergies	○	○

Comments _____

Please List Any Other Significant Information About Your Medical History:

_____

YES	NO	
○	○	Are you under a physician's care at present? If yes, reason_____
○	○	Are you presently, or have you ever been, under the care of a psychiatrist or psychologist? If yes, describe_____
○	○	Are you currently taking any medication? If yes, describe_____
○	○	Are you allergic to any medications? (Eg: aspirin, penicillin, etc.) If yes, what?_____
○	○	Have you ever had any general anesthesia? When?_____

FEMALE PATIENTS

YES	NO	
○	○	Do you have regular menstrual cycles?
○	○	Have you experienced menopause?
○	○	Has anyone in your family had osteoporosis?
○	○	Is there a possibility that you could be pregnant?

DENTAL HISTORY

Dentist Name: _____

YES	NO	
○	○	Do any of your teeth hurt? If yes, upper right ☐ upper left ☐ lower right ☐ lower left ☐
○	○	Does it hurt to chew? If yes, where does it hurt? _____
○	○	Have any wisdom teeth been removed? If yes, how many? _____
○	○	Have you ever had treatment for periodontal disease (gum disease)? If yes, describe _____
○	○	Have you ever had any previous orthodontic treatment (braces)? If yes, when _____ If yes, doctor's name and address _____
○	○	Have there been any injuries to your mouth or teeth? If yes, describe _____
○	○	Have you ever had any injury in the head and neck area? If yes, describe _____
○	○	Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe_____
○	○	Have you ever had any surgery in the head and/or neck area? If yes, describe_____
○	○	Do you clench or grind your teeth? If yes, while sleeping ☐ under stress ☐ other ☐
○	○	Do your jaw muscles ever feel tired? If yes, when_____
○	○	Do you ever notice soreness, tightness or pain in the muscles around the jaw and face? If yes, describe _____

YES NO

Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

	RIGHT	LEFT	SINCE WHEN	DURING WHAT ACTIVITY
☐ Clicking	☐	☐	_____	_____
☐ Grating	☐	☐	_____	_____

Did these joint sounds begin gradually or suddenly? Gradually ○ Suddenly ○

Was there some specific event that started the joint sounds? If yes, describe _____

Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____

Has your jaw ever "locked" closed? If yes, describe _____

Has your jaw ever "locked" wide open? If yes, describe _____

Do you have pain in your jaw joints? If yes, right ☐ left ☐ Since when? _____

Did your pain start gradually or suddenly? Gradually ○ Suddenly ○

During what activity? _____ Describe nature of pain _____

What increases the pain? _____ What decreases the pain? _____

Do you have any of the following habits?

YES NO

- ○ ○ Finger/Thumbsucking
- ○ ○ Lip Biting
- ○ ○ Nail Biting
- ○ ○ Gum Chewing
- ○ ○ Ice Chewing
- ○ ○ Pen/Pencil Chewing

Please describe why you sought this consultation _____

Have you ever been treated for this problem before? If yes, please describe diagnosis and treatment _____

_____

Has any other member of the family had orthodontic treatment?

Has any other member of the family been a patient in this office?

Name _____

We recognize that patients sometimes have specific concerns that may not be addressed by the questions in this Clinical History Form. Please feel free to include any other information regarding your clinical history, or any other concerns that you may have, in the space below. If necessary, please add another sheet of paper.

_____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

(PATIENT'S SIGNATURE) DATE

PATIENT CONSENT FORM
FOR 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. Moe Razavi 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 outline what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

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

Please be assured that every staff person in our office is committed to ensuring that your receive the best quality dental care.

How Our Office Collects, Uses and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

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

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health needs
- to provide health care
- to advise you of treatment options
- to enable us to contact you
- to establish and maintain communication with you
- to offer and provide treatment, care and services in relationship to the oral and maxillofacial complex and dental care generally
- to communicate with other treating health-care providers, including specialists and general dentists who are the referring dentists and/or peripheral dentists, laboratories or pharmacies
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments

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- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete dental claims for third party adjudication and payment
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Royal College of Dental Surgeons of Ontario in a timely fashion, when required, according to the provisions of the *Regulated Health Professions Act*
- to comply with agreements/undertakings entered into voluntarily by the member with the Royal College of Dental Surgeons of Ontario, including the delivery and/or review of patients' charts and records to the College in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to evaluate the dental practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- to deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- to prepare materials for the Health Professions Appeal and Review Board (HPARB)
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

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. 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 the 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 the defence 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 a request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

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 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. Moe Razavi can collect, use and disclose personal information about

_____ as set out above in the information about the office's privacy policies.

_____ _____

Signature Print Name

_____ _____

Date Signature of Witness