CHILD

T: 613.592.7679 F: 613.592.7680 E: doc@palladiumorthodontics.com
www.palladiumorthodontics.com

Thank You for considering us for your child's orthodontic care.
We promise to do our best to provide you and your child 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

School _____ Grade _____

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

Best Cell Phone#_____Best E-mail_____

Parent 1 Name_____
LAST FIRST Relationship to Patient

Marital Status:

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

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

Employed By_____ Occupation_____ Work Tel.# (_____)_____

Does Parent 1 have Orthodontic Insurance ◯ Yes ◯ No

Parent 2 Name_____
LAST FIRST Relationship to Patient

Marital Status:

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

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

Employed By_____ Occupation_____ Work Tel.# (_____)_____

Does Parent 2 have Orthodontic Insurance? ◯ Yes ◯ No

If responsible party is other than the patient's parents, please give information ☐ Not Applicable

Name_____ Relationship to Patient_____

Address _____ Tel.# (_____)_____

Does Responsible Party have Orthodontic Insurance? ◯ Yes ◯ No

MEDICAL HISTORY:

Patient's General Physician Name _____

Has the patient ever had 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 The Patient's Medical History:

_____

_____

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

DENTAL HISTORY

Patient's Dentist Name _____

YES	NO	
○	○	Do any of the patient's 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? _____
○	○	Has the patient ever had treatment for periodontal disease (gum disease)? If yes, describe _____
○	○	Has the patient ever had any previous orthodontic treatment (braces)? If yes, when?_____ If yes, doctor's name and address _____
○	○	Have there been any injuries to the patient's mouth or teeth? If yes, describe _____
○	○	Has the patient ever had any injury in the head and /or neck area? If yes, describe _____
○	○	Has the patient ever fallen and bumped their chin, or received a blow to their jaw? If yes, describe_____
○	○	Has the patient ever had any surgery in the head and neck area? If yes, describe_____
○	○	Does the patient clench or grind their teeth? If yes, while sleeping ☐ under stress ☐ other ☐
○	○	Do the patient's jaw muscles ever feel tired? If yes, when_____
○	○	Does the patient ever notice soreness, tightness or pain in the muscles around the jaw and face? If yes, describe _____
○	○	Does the patient hear clicking (popping) or grating sounds in their 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 ○

YES NO

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

Has the patient ever experienced difficulty in opening or closing their jaws? If yes, describe _____

Has the patient's jaw ever "locked" closed? If yes, describe _____

Has the patient's jaw ever "locked" wide open? If yes, describe _____

Does the patient have pain in their jaw joints? If yes, right ☐ left ☐ Since when? _____

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

During what activity? _____ Describe nature of pain _____

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

Does the patient have any of the following habits?

YES NO

Finger/Thumbsucking

Lip Biting

Nail Biting

Gum Chewing

Ice Chewing

Pen/Pencil Chewing

GROWTH AND DEVELOPMENT

YES NO

Has patient reached adolescent growth? _____

Patient's present height _____ Expected height of patient _____

Father's height _____ Mother's height _____

Girls – Has monthly cycle started yet? If so, when _____

Boys – Has voice changed yet? If so, when _____

Is the patient adopted? If yes, does the patient know? ○ Yes ○ No

Are there any learning disabilities? If yes, explain _____

Are there other children in the family _____

Names and Ages _____

Has any other member of the family had orthodontic treatment?

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

Name _____

Please describe why you sought this consultation _____

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

_____

Any information you can give us concerning your child will be appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies:

_____

_____

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 the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

(SIGNATURE OF RESPONSIBLE ADULT) 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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T: 613.592.7679 • F: 613.592.7680 • www.palladiumorthodontics.com • doc@palladiumorthodontics.com

- 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