Dr. N. Pershad
Orthodontist

Child Patient History Form

Name ____Age____ Sex____ DOB_________ Grade_____ School______________

Address__________________________________City_______________Postal Code_________ Tel _____________________

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

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

Name____ Relationship to patient________________________________

Address ____Home Tel _______________Work Tel_______________

Does responsible party have Orthodontic Insurance? Yes No Name of Ins company_________________________________

MEDICAL HISTORY: Physician:____________________________Phone:________________________

Has patient had or does patient have any of the following?

Rheumatic fever	Y	N	Herpes	Y	N	Prolonged Bleeding	Y	N	Asthma	Y	N
Heart Murmur	Y	N	Tuberculosis	Y	N	Epilepsy	Y	N	Swollen glands	Y	N
Mitral Valve Prolapse	Y	N	HIV/ AIDS	Y	N	Mental health problems	Y	N	Arthritis	Y	N
Heart Disease	Y	N	Hepatitis A, B or C	Y	N	Diabetes	Y	N	Allergies	Y	N
Artificial Heart Valve	Y	N	STD's	Y	N	Kidney disease	Y	N	Other:__________________		
Artificial Joints	Y	N	Blood disease	Y	N	Liver Disease	Y	N	______________________		

If you responded YES to any of the above, please give other significant information ______________________________________

____

Is the child under a physician's care at present? If yes, reason____

Does the child have any history of major illness and/ or operations? ____

Is the child allergic to any medications? (e.g. aspirin, penicillin, etc.) If yes, what? ____________________________________

Please list any medications being taken____

Does the child have tendency to colds? ____________________ Sore throats? ________________ Ear infections?____________

Have the tonsils or adenoids been removed?____

Has the patient reached puberty? Girls-Has menstruation started? Yes No Boys-Has voice changed? Yes No

Are there other children in the family? Names and ages____

Has any other member of the family had orthodontic treatment?_______________________________ At this office? Yes No

Please describe why you sought this consultation____

____

DENTAL HISTORY: Dentist:___________________________Date of last visit:_____________________

Yes No

Does the child require any dental work including cleanings, extractions or fillings?_____________________________

Have there been any injuries to the child's face, mouth or teeth? If yes, describe_________________________________

Has the child ever fallen and bumped their chin, or received a blow to their jaws? If yes, describe___________________

Have you been informed of any missing or extra permanent teeth? If yes, list__________________________________

Has the child ever had any surgery in the head and neck area? If yes, describe_________________________________

Has the child ever sucked his/her thumb/finger? _________________ Until what age?___________________________

Has the child ever had a orthodontic examination? _____________ Does the child want treatment?________________

List any sports, hobbies or musical instruments:____

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 Parent or Guardian Date

____ ______________________________________

Doctor Date

NOTES:____

Patient Privacy Consent Form

Privacy of your personal information is an important part of our office protocol to provide 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. Neeraj Pershad** 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:

- 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 Federal law.

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

- to deliver safe and efficient patient care
- to identify and to ensure continuous high quality service
- to assess your health needs
- to provide safe 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 physicians, specialists and general dentists who are the referring dentists and/or peripheral dentists
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care and billing
- for teaching and demonstrating purposes on an anonymous basis
- to complete and submit 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 prepare materials for the Health Professions Appeal and Review Board (HP ARB)
- to invoice for goods and services
- to process payments
- to assist this office to comply with all regulatory requirements
- to comply generally with the law

Dr. Pershad will attempt to answer any questions or concerns that you might have. If you do have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing. Please send it to our office's Privacy Information Officer by surface mail. Our Privacy Information Officer will promptly acknowledge receipt of your complaint in writing and will insure that it is investigated thoroughly. You will be provided with a formal decision in writing and the reasons for the decision. If you are dissatisfied with the decision, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information listed below.

Privacy Commissioner of Canada, 112 Kent Street, Ottawa, On. KIA IH3
Phone: 613 995-8210 Toll Free: 1 800 282-1376

Our privacy policies and procedures comply with federal legislation called the Personal Information Protection and Electronic Documents Act (PIPEDA). This very complex law does provide for some exceptions to the privacy principles that are too detailed to outline here. Our Privacy Code sets out this dental office's commitment to protecting your private health and personal information. It is available on request by asking any of our office staff.

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. Our office will not under any conditions supply anyone 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. Pershad** can collect, use and disclose personal information about ______________________________ as set out above in the information about this office's privacy policies.
(Patient Name)

______________________________ ______________________________
Signature Print Name

______________________________ ______________________________
Date Signature of Witness