PATIENT CONSENT FORM

COLLECTION/USE OF PERSONAL INFORMATION

We are dedicated to maintaining high standards of confidentiality regarding your Personal Information. Please refer to our Privacy Policy for more information on our privacy practices.

I hereby consent to Lotus Family Dental's use of my Personal Information that I have given to Lotus Family Dental or that Lotus Family Dental has collected by proper means.

If you do not agree with these terms, you are requested not to provide any Personal Information to Lotus Family Dental. If you choose not provide us with any required Personal Information, we may not be able to offer you certain services to you.

There may be circumstances where you have provided Personal Information for an identified purpose, and Lotus Family Dental later needs to use that information for a different purpose. In such circumstances, Lotus Family Dental will seek your consent to use the information for the new purpose.

Please note that there are circumstances where the use and/or disclosure of Personal Information may be justified or permitted or where Lotus Family Dental may or must disclose information without consent, in accordance with applicable laws.

Where obliged or permitted to disclose information without consent, Lotus Family Dental will not disclose more information than is required for the purpose that obligates or permits us to disclose such information.

You have the right to revoke your consent to the collection, use and disclosure of your Personal Information at any time. However, revocation of your consent may result in our inability to provide services to you.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THE FOREGOING IN ITS ENTIRETY AND CONSENT TO LOTUS FAMILY DENTAL'S COLLECTION AND/OR USE OF MY PERSONAL INFORMATION.

_____

Signature

PRIVACY POLICY

Lotus Family Dental is dedicated to maintaining high standards of confidentiality regarding your Personal Information. This Privacy Policy has been prepared to inform you of our practices concerning the collection, use and disclosure of your Personal Information.

COLLECTION OF PERSONAL INFORMATION

When you become of patient of Lotus Family Dental, you voluntarily provide us with certain Personal Information related to your oral health. Personal Information collected by Lotus Family Dental is only used to provide you with oral care services or to provide you with information regarding those services. Lotus Family Dental will only collect your Personal Information by lawful means and only for necessary purposes that have been disclosed to you. Under no circumstances will Lotus Family Dental sell, trade, barter or exchange for consideration any Personal Information it has obtained.

ACCOUNTABILITY

Lotus Family Dental is responsible for all Personal Information under its control, including the transfer of Personal Information to a third party service provider for processing on Lotus Family Dental behalf.

STORAGE AND SECURITY

At Lotus Family Dental, your Personal Information may be stored electronically. We have in place physical, electronic, technological and organizational safeguards to appropriately protect the security and privacy of your Personal Information against loss, theft, and unauthorized access, disclosure, copying use or modification. Your Personal Information will be collected, processed, stored and used by Lotus Family Dental and may be passed to and processed by other companies under the instruction of Lotus Family Dental. Your Personal Information may be processed and/or stored outside of Canada. If your Personal Information is transferred outside of Canada, it may be available to the foreign government of the country in which the information or entity controlling it is situated under a lawful order made in that country. By providing us with your information, you are allowing your Personal Information to be transferred outside of Canada.

ACCESSING AND UPDATING YOUR PERSONAL INFORMATION

Lotus Family Dental endeavours to ensure that any Personal Information provided and in its possession is as accurate, current and complete as possible. You have a right to request access to your Personal Information and to request a correction to it if you believe it is inaccurate. In the event that you believe that your Personal Information is not accurate or you wish access to your Personal Information, you may request verification for accuracy. If you contact us about your Personal Information, we will respond to your request within a reasonable time and at no cost to you.

Lotus Family Dental will only release your Personal Information with your consent. However, Lotus Family Dental must comply with valid statutes that require it to disclose information to officials as part of an investigation.

If you require more information or clarification on our Privacy Policy, please do not hesitate to contact us.

I ACKNOWLEGDE THAT I RECEIVED A COPY OF LOTUS FAMILY DENTAL'S NOTICE OF PRIVACY PRACTICES.

_____

Signature

CONFIDENTIAL PATIENT INFORMATION

PATIENT'S NAME Last First Middle	DATE OF BIRTH (MM/DD/YY)	Gender ☐ F ☐ M

PATIENT'S ADDRESS	Home Phone #	Cell phone #	Work Phone #
	By which way do you prefer to communicate with us? (Check more than one choices if necessary) ☐ Home # ☐ Cell # ☐ Work # ☐ Text ☐ Email		

MARITAL STATUS	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

EMAIL ADDRESS (Your email address will be in confidence and only used for office communication with you)

SPOUSE'S NAME Last First Middle	SPOUSE'S EMPLOYER	OCCUPATION

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME: **RELATIONSHIP:** **WORK NO.** **HOME NO.**

HOW DID YOU HEAR ABOUT US?

☐ **FRIENDS/FAMILY (Please Name so we can thank them :_____)** ☐ **Internet (Website, facebook)** ☐ **Drive- By**

☐ **Phonebook (please name if known: _____)** ☐ **Newspaper (please name if known: _____)**

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS

SUBSCRIBER'S NAME (If different from above)	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE/COMMONLAW ☐ DEPENDENT	SUBSCRIBER D.O.B (If different from above)	SUBSCRIBER'S S.I.N. (Optional)

Group Number AND ID Number	EMPLOYER	EMPLOYER'S ADDRESS

SECONDARY INURANCE COVERAGE ☐ YES ☐ NO	2nd INSURANCE COMPANY NAME	2nd INSURANCE ADDRESS

SUBSCRIBER'S NAME (If different from above)	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE/COMMONLAW ☐ DEPENDENT	SUBSCRIBER D.O.B (If different from above)	SUBSCRIBER'S S.I.N. (Optional)

GROUP/PROGRAM NUMBER	EMPLOYER (If different from above)	EMPLOYER'S ADDRESS

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask any questions and receive answers to any questions regarding my medical-dental history. I realize that the dentist is a general practitioner who offers many specialized treatments to patients. Should there be any change in my health status in the future, I will advise this dental office.

I authorize the office to submit any necessary pre-determinations inquiring further information about my dental benefits for recommended treatments.

I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary.

I consent to the use of photographs and radiographs for dental journals, teaching, and marketing purposes, provided that identity is strictly hidden.

I consent to the responsibility for payment of the dental services for myself and my dependents is mine solely and I assume responsibility for fees associated with these services. I understand this office requires **48 hour** notification to avoid any minimum charges.

Patient's or Guardian's Signature _____ **Date** _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex _____		
☐ nuts _____		
☐ fruit _____		
☐ milk _____		
☐ red dye _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD diagnosis _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
47. speech difficulties or delayed growth at any time _____	☐	☐
ARE YOU:		
48. presently being treated for any other illness _____	☐	☐
49. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
50. taking medication for weight management _____	☐	☐
51. taking dietary supplements _____	☐	☐
52. often exhausted or fatigued _____	☐	☐
53. experiencing frequent headaches or chronic pain _____	☐	☐
54. a smoker, smoked previously or use smokeless tobacco _____	☐	☐
55. considered a touchy/sensitive person _____	☐	☐
56. often unhappy or depressed _____	☐	☐
57. taking birth control pills _____	☐	☐
58. currently pregnant _____	☐	☐
59. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Blood Pressure :(/) Pulse: ( ) **ASA** _____ **(1-6)**

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____