CENTRE DENTAIRE ST. LAURENT DENTAL CENTRE

PRIVACY POLICY

Our office understands the importance of protecting your personal information.
This office will collect, use, and disclose information about you for the following purposes:

- To assess your health needs and provide safe and efficient dental care.
- To enable us to contact and maintain communication with you to distribute health-care information and to schedule and confirm appointments.
- To communicate with other treating health-care providers, including other dentists, physicians, pharmacists, and lab technicians.
- 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.
- To deliver your charts and records to the dentist's insurance carrier to enable the insurance company to assess liability and quantify damages, as necessary.
- To invoice for goods and services.
- To collect unpaid accounts.
- To process credit card payments.

At our office, all professional dentistry services are performed by licensed members of the Royal College of Dental Surgeons of Ontario (the "Dental Professionals"), and all institutional health care services are performed independently by St. Laurent Health Services under clinical supervision and control of Health Professionals, in a cost-sharing arrangement. St. Laurent Dental and St. Laurent Health Services are independent corporations providing respective services. One or more of our Dental Professionals has a financial interest in St. Laurent Health Services.

By signing this form, the undersigned acknowledges and agrees that they have read and understood the information and disclosure set forth herein prior to any professional services being provided to the undersigned by and Dental Professionals working with St. Laurent Dental.

☐ **I consent to receive emails from St. Laurent Dental Centre.**

Patient / Parent / Guardian Name (Print): _____

Patient / Parent / Guardian Signature: _____

CENTRE DENTAIRE ST. LAURENT DENTAL CENTRE

Your cooperation in completing this form is essential to help us provide you with the highest possible standard of dental care.
All information is strictly confidential and is protected by doctor-patient confidentiality.

PATIENT INFORMATION

Title | Full Name | Preferred Name

Address | City | Postal Code

Primary Phone # | Secondary Phone # | Email

Date of birth (MM/DD/YYYY) | Gender | Occupation

PARENT OR GUARDIAN INFORMATION

Only fill out this section if the patient is 14 years old or younger. If the field is the same as the patients, please leave it blank.

Title | Full Name | Relationship to Patient

Address | City | Postal Code

Primary Phone # | Secondary Phone # | Email

EMERGENCY CONTACT INFORMATION

Title | Full Name

Primary Phone # | Secondary Phone # | Email

DENTAL INSURANCE

Does the patient have dental insurance? ◯ Yes ◯ No

Insurance Company | Name of Policy Holder

Policy Number | Date of Birth of Policy Holder

Certificate Number | Employer of Policy Holder

Please tell us how you heard about St. Laurent Dental.
If this was a referral, whom may we thank?

DENTAL HISTORY QUESTIONNAIRE

Why has the patient come to the dentist today?

How would you describe the condition of the patient's teeth and gums? ◯ Good ◯ Fair ◯ Poor

Date of patient's last dental visit (MM/YYYY) | Name of previous Dentist

How often does the patient brush? | How often does the patient Floss?

Does the patient's gums bleed when they brush? ◯ Yes ◯ No

Has the patient ever experienced pain in their jaw joint? ◯ Yes ◯ No

Has the patient ever been treated for T.M.D. (T.M.J.) symptons? ◯ Yes ◯ No

Is the patient happy with the appearance of their teeth? ◯ Yes ◯ No

Is there any additional information which may be helpful in the care of the patient?

CENTRE DENTAIRE
ST. LAURENT
DENTAL CENTRE

PATIENT INFORMATION

Full Name _____

MEDICAL HISTORY QUESTIONNAIRE

1. When was the patient's last medical check up?
2. Please list any and all allergies the patient has:
3. Is the patient being treated or received treatment for any medical condition during the past year? If so, Why?
   ◯ No ◯ Yes:
4. Has there been any changes in the patient's general health in the past year? If yes, please explain.
   ◯ No ◯ Yes:
5. Is the patient taking any medications, non-prescription drugs, or health supplements of any kind? If so, please list.
   ◯ No ◯ Yes:
6. Has the patient ever had a peculiar or adverse reaction to any medications or injections? If yes, please explain.
   ◯ No ◯ Yes:
7. Does the patient have or has the patient ever had asthma?
   ◯ No ◯ Yes
8. Does the patient have or has the patient ever had any heart or blood pressure problems?
   ◯ No ◯ Yes:
9. Has the patient ever had a replacement or repair of a heart valve, an infection of the heart (E.G. infective encocarditits), a heart condition from birth (e.g. congenital heart disease) or a heart transplant?
   ◯ No ◯ Yes
10. Does the patient have a prosthetic or artificial joint?
    ◯ No ◯ Yes:
11. Does the patient have any conditions or therapies that could affect their immune system (e.g. Leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?
    ◯ No ◯ Yes
12. Does the patient have or has the patient ever had hepatitis, jaundice, or liver disease?
    ◯ No ◯ Yes
13. Does the patient have a bleeding problem or bleeding disorder?
    ◯ No ◯ Yes
14. Has the patient ever been hospitalized for any illness or operation? If yes, please explain
    ◯ No ◯ Yes:
15. Does the patient have or has the patient ever had any of the following?

◯ Arthritis	◯ Drug/alcohol dependency	◯ Lung disease	◯ Rheumatic fever	◯ Stomach ulcers
◯ Cancer	◯ Heart attack	◯ Mitral valve prolapse	◯ Seizures (Epilepsy)	◯ Stroke
◯ Chest pain/angina	◯ Heart murmur	◯ Osteoporosis	◯ Shortness of breath	◯ Thyroid disease
◯ Diabetes	◯ Kidney disease	◯ Pacemaker	◯ Steroid therapy	◯ Tuberculosis

16. Are there any conditions or diseases that are not listed above that the patient has had or has? If so, please list.
    ◯ No ◯ Yes:
17. Does the patient smoke or chew tobacco products?
    ◯ No ◯ Yes
18. Is the patient nervous during dental treatment?
    ◯ No ◯ Yes
19. Is the patient breastfeeding or pregnant? If the patient is pregnant, what is the expected delivery date?
    ◯ No ◯ Yes:

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ON THIS FORM IS CORRECT

Patient / Parent / Guardian Signature: _____ **Date:** _____

Dentist Signature: _____ **Date:** _____