BloorWestSmiles

general | cosmetic | implants | braces

Welcome to Our Office

We look forward to becoming partners in your dental health care. Our approach to dentistry is prevention oriented and is a team effort involving you and our staff. Together we will address any current dental concerns and endeavour to prevent future dental problems.

PERSONAL INFORMATION

Title_____ First Name_____ Last Name _____

Nickname:_____ Martial Status:_____ Sex: M F Date of Birth: ____ / ____ / ___ (DD / MM / YY)

Address: _____

Unit #:_____ City: _____ Province:_____ Postal Code: _____

Home Phone #: _____ Business Phone #: _____ Ext:_____

Cell #: _____ E-mail: _____

Employer: _____ Occupation: _____

Physician: _____ Phone #: _____

How Did You Hear About Our Clinic? _____

In case of emergency, please notify: _____ Relation: _____ Phone: _____

FINANCIAL INFORMATION

Person responsible for this account: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other _____

First Name:_____ Last Name: _____ Relationship:_____ Date of Birth: ____ / ____ / ____ (DD / MM / YY)

Home Phone #: _____ Cell Phone #: _____ Business Phone #: _____ Ext: _____

Financial Information _____

PRIMARY INSURANCE

Subscriber: First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____ (DD / MM / YY)

Insurance Company: _____ Employer/Policy Holder: _____

Policy or Group #: _____ Certificate or ID #: _____ Division: _____

SECONDARY INSURANCE

Subscriber: First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____ (DD / MM / YY)

Ins. Company: _____ Employer: _____ Policy #:_____ ID#:_____

I consent to my physician being contacted, if necessary, as this information may be required for my dental care. I also assume responsibility for any fees associated with the dental services provided by Dr. Kostirko and/or his associates. I authorize release; to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. Kostirko. This authorization shall continue in effect until the undersigned revokes the same. I hereby assign my benefits, payable from claims submitted electronically, to Dr. Kostirko and/or associates and authorize payment directly to him/her.

Signature of patient, parent or guardian: _____ Date: _____

If parent/guardian, please print name (First, Last):_____

MEDICAL HISTORY

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

1. Are you currently being treated for any medical condition or have you been treated within the past year? ☐YES ☐NO

If so, why? _____

2. When was your last medical checkup? _____

3. Has there been any change in your general health in the past year? (i.e. unexplained weight, appetite or frequency of urination changes)

☐YES ☐NO If so, please explain. _____

4. Have you ever been hospitalized for any illnesses or operations? ☐YES ☐NO

If so, please explain. _____

5. Are you taking any medications, non-prescription drugs or herbal supplements of any kind ☐YES ☐NO

If so, please list. _____

6. Are you on any special diet? (e.g. salt restricted diet). If so, why? _____ ☐YES ☐NO

7. Have you had antibiotics in the last 3 months? If so, why? _____ ☐YES ☐NO

8. Do you bruise easily or have bleeding problem or bleeding disorder? _____ ☐YES ☐NO

9. Have you ever fainted, had shortness of breath or chest pains? If so, what were the circumstances? ☐YES ☐NO

_____

10. Do you suffer from canker sores or cold sores? _____ ☐YES ☐NO

11. Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infections, radiotherapy, chemotherapy? _____ ☐YES ☐NO

12. Have you ever had hepatitis, jaundice or liver disease? _____ ☐YES ☐NO

13. Do you have any organ transplants or joint replacements? If so, since when? _____ ☐YES ☐NO

14. Do you have any allergies? Including: medications, foods, latex, environmental, other? ☐YES ☐NO

If so, please list: _____

15. Have you ever had an adverse reaction to any of the following. If so, explain: _____ ☐YES ☐NO

Aspirin Penicillin Codeine Latex Dental Freezing Other: _____

16. Have you ever had an adverse reaction to metal or metal jewelry. If so, explain: _____ ☐YES ☐NO

17. Have you been told by your medical doctor that you need to take antibiotics before dental treatments?. ☐YES ☐NO

18. Are there any diseases or medical problems that run in your family?(e.g. diabetes, cancer or heart disease)

☐YES ☐NO If so, please explain. _____

19. Do you have or have you ever had asthma? If so, since when? _____ ☐YES ☐NO

20. Do you smoke or chew tobacco products? If so, how many / how often? _____ ☐YES ☐NO

MEDICAL HISTORY

21. Do you have or have you ever had any of the following? Please circle.

Organ Transplant	**Joint / Hip Replacement**	**Pacemaker**	**Head / Neck Injuries**
High Blood Pressure	**Congenital Heart Disease**	**Stroke / Heart Attack**	**Mitral Vale Prolapse**
Anemia / Blood Disorders	**Heart Valve Replacement**	**Heart Murmur**	**Chest Pain / Angina**
Ulcers / Stomach Disorder	**Emphysema / Lung Disease**	**Kidney Disease**	**Thyroid Disease**
Gall Bladder Disorders	**Liver Disease / Hepatitis A/B/C**	**Osteoporosis**	**Arthritis / Rheumatism**
Sinus or Nasal Problems	**Diabetes, Hyper / Hypoglycemia**	**Steroid Therapy**	**Tuberculosis**
Mental / Nervous Disorders	**Down Syndrome / Cerebral Palsy**	**Epilepsy / Seizures**	**ADD / Autism**
Drug / Alcohol Dependency	**Sexually Transmitted Disease**	**H.I.V. / A.I.D.S.**	**Eczema / Psoriasis**
Deafness or Blindness	**Multiple Sclerosis**	**Cancer**	**Rheumatic Fever**

• Please list any conditions or diseases not listed above that you have or have had: _____

For women only:

Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date? _____ ☐ *YES* ☐ *NO*

Are you taking birth control pills? _____ ☐ *YES* ☐ *NO*

Are you menopausal or post-menopausal? If so, are you on hormone replacement therapy? _____ ☐ *YES* ☐ *NO*

DENTAL HISTORY

1. What has brought you to our office today? _____

2. How often do you usually visit a dental office? _____ When was your last visit? _____

3. What was done at last visit?? _____ Were X-rays taken? ☐YES ☐NO

4. Have you ever had a negative dental experience? If yes, please explain: _____ ☐YES ☐NO

5. Are you generally tense during dental treatment? ☐YES ☐NO

6. Have you ever suffered an accident involving your face or jaws? If so, when? _____ ☐YES ☐NO

7. Do you have any of the following? Please circle. **Discomfort** **Pain** **Sensitivity** **Infection / Swelling**

If so, where? _____ Since when: _____

8. Do you have any of the following? Please circle.

			Broken fillings or teeth
Bad breath	**Food collection between teeth**	**Periodontal treatment**	**Bleeding or irritated gums**
Loose teeth	**Sores or growth in mouth**	**Clicking or popping jaws**	**Grinding or clenching teeth**

9. How many times a day do you brush? _____ How many times a day do you use floss? _____

10. If there is anything you would change about your smile, what would it be? _____

To the best of my knowledge, the above information is correct and I have not omitted any pertient information. I hereby consent to performing whatever is deemed necessary for proper diagnosis and treatment. These may include the use of x-ray, local anesthesia, and other medication. I understand that treatment options will be discussed and I have the right to be provided answers to questions which may arise during the course of treatment. Further, I understand the risk, benefits, and possible complications of dental treatment. I also understand that complications could change treatment.

Patient / Parent / Guardian Signature: _____ Name (Please print): _____ Date: ____ / ____ / ____
(DD / MM / YY)

Dentist Signature _____ Date: _____ / _____ / ____
(DD / MM / YY)

PATIENT CONSENT FORM
– COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

As dental professionals we are required to comply with **Federal and Provincial Privacy Legislation, (PIPEDA) and (PHIPA)**. In order to do so, each of our patient's must sign a consent form acknowledging and allowing us to collect, use and disclose personal information according to specific guidelines. At BloorWestSmiles, the privacy of your personal information is of utmost importance. We are committed to collecting, using and disclosing your personal information responsibly. Our policies regarding your personal information are open and transparent.

In this office, Dr. Alexandre Kostirko acts as the Privacy Information Officer. All staff members are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate uses and protection of your information; we are committed to adhering closely to our Privacy Code. Please do not hesitate to discuss and review our policies and Privacy Code with any member of our team.

We limit the collection of personal information to only the relevant and necessary information. Your personal information will be stored, retained and destroyed in compliance with the existing legislation and privacy protection protocols of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the federal legislation of the Personal Information Protection and Electronic Documents Act (PIPEDA).

In our office we will collect, use and disclose your personal information for the following purposes:

- to accurately assess your overall medical and dental health in order to provide safe, efficient, quality orthodontic and dentofacial orthopedic assessment, diagnosis and treatment
- to establish and maintain communication with you in regards to all aspects of your care, including assessment, diagnosis, treatment, and your financial matters
- to communicate with your team of health care professionals (e.g. general dentists, dental specialists, medical doctors) in order provide the highest level of comprehensive care in a cohesive manner
- for teaching and demonstrating purposes on an anonymous basis
- to comply with all legal and regulatory requirements of provincial and federal laws
- to comply with all regulations set forth by the Royal College of Dental Surgeons of Ontario

PATIENT ACKNOWLEDGEMENT AND CONSENT

I have reviewed the above information regarding the collection, use, and disclosure of the personal information, and have been given the opportunity to ask questions about the steps your office is taking to protect this information.

I acknowledge and agree that the office of BloorWestSmiles and Dr. Alexandre Kostirko can collect, use and disclose the personal information as described above, and in accordance with the Privacy Code of their office.

Patient or Parent/Guardian Name _____
(PLEASE PRINT)

Patient or Parent/Guardian Name _____
(SIGNATURE)

Witness _____

Date _____