DR. MICHAEL DUCHNAY - D.M.D., M.Sc., F.R.C.D. (C)
ORAL MEDICINE SPECIALIST

Patient Name: _____ D.O.B _____
Address: _____ Apt#: _____
City/Province: _____ Postal Code: _____
Home Phone: _____ Work: _____ Cell: _____
Email: _____
Emergency Contact Name: _____ Phone: _____
Ontario Health Card #: _____
Do you have dental insurance: Yes/No Insurance Co: _____
Policy No: _____ Division No: _____ Certificate/Id No: _____

Family Physician: _____ Phone: _____
Address: _____ Last Visit: _____
Family Dentist: _____ Phone: _____
Address: _____ Last Visit: _____
Specialists: _____ Phone: _____
Pharmacy Name: _____ Phone/Address: _____
Who referred you to our clinic? _____
For what reason: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1) Are you currently under the care of a medical doctor or specialist? YES/NO
Why? _____
2) Have you ever had any type of operation or serious illness? YES/NO
If yes, please explain: _____
3) Has there been any change to your health in the last year? YES/NO
If yes, please explain: _____
4) Are you taking any drugs, pills, medicine or over the counter (non-Prescription) medications including vitamins and herbal supplements? **PLEASE LIST or attach a list of your medications.** _____
_____
5) Do you have any allergies to Medications, Latex, rubber products/other materials? YES/NO
If yes, please list: _____
Do you have allergies to kinds of food, and environmental? YES/NO
If yes, please list: _____
What was the reaction? _____
6) Have you ever had a bad reaction to local anesthetic or general anesthetic? YES/NO
If yes, please describe: _____
7) Do you now use, of have you used within the past five years, ANY recreational or street drugs or substance? YES/NO
If yes, which ones and how often? _____
8) Do you drink beer, wine, liquor, or other alcoholic beverages? YES/NO
How often? _____ How much? _____

9) Have you had radiation, chemotherapy, or other treatments for cancer, tumor, bowel problems, joint, or skin problem disorders? YES/NO
Please describe: _____
10) Have you ever been admitted to a hospital? YES/NO
If yes, why? _____

CHECK THE PROBLEMS YOU NOW HAVE OR HAVE HAD IN THE PAST

CENTRAL NERVOUS SYSTEM:

__Head Injury __Psychiatric Disorder __Recurring Headaches
__Migraine __Sight/Hearing Disorder __Development Delay
__Epilepsy __Malignant Hyperthermia __Seizures or Convulsions
__Stroke __Nervous Disorder __Facial Pain Disorder
__Fainting Spells __Autism/ADD/ADHD __ Multiple Sclerosis (MS)
__Cerebral Palsy __Parkinson's Disease __Alzheimer's/Dementia
__Sleep Problem (e.g., sleep apnea)
__Cognitive Impairment (e.g., Memory/Concentration)

ENDOCRINE SYSTEM:

__Diabetes: Type I □ Type II □ __Hormone Problems __Thyroid Problems
__HRT __Pituitary Problems

GENITOURINARY SYSTEM:

__Kidney Problems __Bladder Problems __Prostate Problems
__Renal Failure __Urinary Tract Problems __Dialysis Peritoneal/Hemodialysis

CARDIOVASCULAR SYSTEM:

__Heart Attack __Shortness of Breath __Easy Bruising
__Congestive Failure __Angina/Chest Pains __Congenital Heart Disease
__Rheumatic Fever __Heart Surgery __Do you have a pacemaker?
__Anemia __ __High/Low Blood Pressure __Bleeding/Clotting Disorder
__Heart Murmur/Mitral Valve Prolapse __Irregular Pulse/Heartbeat
__Limits to walking/work/exercise/sports
__Prolonged Bleeding(e.g. after cut or dental extraction)
__Have you had a Blood or Blood-Product Transfusion
__Blood clots in the leg or other blood vessels (deep vein thrombosis)
__Artificial/Prosthetic Heart Valve or Artery/Vein

RESPIRATORY SYSTEM:

__Hay Fever __Lung Disorder __Asthma __Pneumonia
__Shortness of Breath __Sleep Apnea __Collapsed Lung __Emphysema
__Tuberculosis (TB)
__Nasal or Sinus Problems
__Pulmonary Embolus/Blood clot
Do you smoke? YES/NO If yes, what/how much/for how long? _____

GASTROINTESTINAL SYSTEM:

__Recurring Mouth Ulcers __Hepatitis/Jaundice __Swallowing Problem
__Stomach/Intestinal Ulcers __Cannot take Aspirin __Hiatus Hernia
__Liver Disease __Chronic Constipation __Intestinal/Bowel Disorders
__Upset stomach or Diarrhea when taking medications __ Irritable Bowel Syndrome

IMMUNE SYSTEM CONCERNS:

__ Crohn's Disease- Which medications are you taking? _____
__ Rheumatoid or other types of Arthritis- Which medications are you taking?
_____
__ Multiple Myeloma/Breast Cancer/other cancers- Which medications are you taking?
_____
__ HIV/AIDS- Which medications are you taking?
_____

MUSCULOSKELETAL SYSTEM:

__Jaw Joints Problems __Physical Impairment/Disability __Dental Implants
__Osteoporosis __Arthritis or Joint Problems __Artificial/Prosthetic Joint
__Quadriplegia/ Paraplegia
Are you taking a specific type of medications called Bisphosphonates? YES/NO
Are you taking any medication to increase bone density? YES/NO

SKIN:

__Skin Lesions/ Disorders __Allergy/Hives/Rashes

WOMEN: Are you pregnant? YES/NO Are you breast feeding? YES/NO

FAMILY HISTORY:

Is there anyone in your family who has or has had any of the following: If yes, please check
Heart or Blood pressure problems __ Bleeding Disorder __ Diabetes __

Do you have or have you any other medical problem or condition that has not been asked?
If yes, please describe: _____

I acknowledge that I have completed the medical history to the best of my knowledge. I consent to contact with my dentist, physician, or other health care provider regarding clarification of my medical history and to the sharing/reporting of medical information and my treatment at our office.

Patient/Guardian Signature: _____ Date: _____

THE BLOOR CLINIC TORONTO DENTAL SPEACIALTY GROUP

PATIENT CONSENT FORM: FOR COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

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

Privacy of personal information is an important principle in the provision of quality dental care to out patients. We understand the importance of protecting your personal information. Our office has taken appropriate measures to safeguard your personal information from unauthorized access, disclosure, use or tampering. To help you understand how we handle your personal information, we have outlined here how our office is using and disclosing your information:

- **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 protocol complies with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario and the law.

In this office **Dr.Duchnay** acts as the **Privacy Information Officer**

Please do not hesitate to discuss our policies with myself, or any member of our staff.

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 healthcare providers, including 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 healthcare 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 patient's charts and records to the College 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 patient's 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

All staff members who encounter your personal information are mindful of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate use and protection of your information.

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 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 for legal issues. Our office will not under any circumstances supply your insurer with your confidential medical information. If this type of request is made, we will forward the information directly to you for review and obtain your consent for this specific matter. When unusual requests are received, we will contact you directly 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 **The Bloor Clinic Toronto Dental Speciality Group** can collect, use and disclose personal information about the patient noted below and as set out above in the information about the office's privacy policies.

_____ _____

Signature **Print Name**

_____

Date

THE BLOOR CLINIC
DENTAL SPECIALTY GROUP

Financial Consent Form for Insurance + Non-Insurance Clients

I_____ am aware of the office policy at The Bloor Clinic Dental Specialty Group. I understand and consent that payment is required upfront in full for all dental treatment. I understand even though I have or don't have dental insurance that I am personally responsible for the payment of services rendered at the time of treatment. I am aware that if I have insurance, my insurance company will reimburse me based on my plan coverage.

PLEASE NOTE CHEQUES OR E-TRANSFERS ARE NOT ACCEPTED

_____ _____ _____

Signature of Patient/Guardian Witness Date

3250 Bloor St West, Unit 115 Toronto, ON M8X 2X9
t: (437) 774 - 8221 f: (437) 800-4441
info@thebloorclinic.com
www.thebloorclinic.com