Adult Patient Consent Form

For collection, use and disclosure of personal information
Privacy of your personal information is an important part of our office, providing you with quality dental care. We understand the importance of protecting your personal information. We are committed to collection, using and disclosing your personal information.

All employees of Georgian Mall Dental Group who may come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. Our employees are all trained on PIPEDA (The Personal Information Protection and Electronic Act) this is a Canadian law relating to data privacy. It governs how the private sector organizations collect, use and disclose personal information in the course of commercial business.

I, ________________________________ hereby certify that I have been notified of the PRIVACY POLICIES OF GEORGIAN MALL DENTAL GROUP

Signature: ___________________________ Checked by: ________________________________

☐ Patient   ☐ Parent   ☐ Guardian Checked by:

Print Name: ___________________________
Signature: ___________________________
Date: ________________________________

Consent for electronic billing
I authorize release, to my dental benefit 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 the named dentists. This authorization shall continue in effect, until the undersigned revokes the same.

Signature of Patient, Parent / Guardian: ___________________________ Date: ________________________________
The Following information is required to enable us to provide you with the best possible 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 out this entire form.

Full Name: ____________________________ Relationship: ____________________________

Date of birth (DD/MM/YY): __________ / __________ / __________

Address (home): ____________________________

Doctor's phone/address: ____________________________

Phone (home): ____________________________

Address (bus.): ____________________________

Area of specialty: ____________________________

Phone (bus.): ____________________________

Marital status: ____________________________

Email: ____________________________

Health card no.: ____________________________

Employer: ____________________________

Specialist's phone/address: ____________________________

Occupation: ____________________________

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Medical Alert: 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.

Full Name: ___________________________ Relationship: ___________________________
Date of birth (DD/MM/YY): __________/________/________ Day-time phone: _________________________
Address (home): _________________________ Family doctor: _____________________________
Doctor’s phone/address: _________________________
Phone (home): ____________________________
Address (bus.): ____________________________ (1) Name of medical specialist: _______________________
Area of specialty: ____________________________
Phone (bus.): ____________________________ Specialist’s phone/address: _________________________
Marital status: ____________________________
Email: ____________________________ (2) name of medical specialist: _________________________
Health card no.: ____________________________ Area of specialty: ____________________________
Employer: ____________________________
Specialist’s phone/address: ____________________________
Occupation: ____________________________

1. Are you currently being treated for any medical condition or have you been treated within the past year? If yes, please explain.
   ○ Yes  ○ No  ○ Not sure/ Maybe ____________________________

2. When was your last medical checkup? ____________________________

3. Has there been any change in your general health in the past year? If yes, please explain.
   ○ Yes  ○ No  ○ Not sure/ Maybe ____________________________

4. Are you taking any medications, non-prescription drugs, or herbal supplements of any kind? If yes, please list them.
   ○ Yes  ○ No  ○ Not sure/ Maybe ____________________________
5. Do you have any allergies? If yes, please list them using the categories below:
   ❍ Yes  ❍ No  ❍ Not sure/ Maybe
   a) Medications: ________________________________
   b) Latex/rubber products: __________________________
   c) Other: ________________________________

6. Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.
   ❍ Yes  ❍ No  ❍ Not sure/ Maybe ___________________________________________

7. Do you have or have you had asthma?  ❍ Yes  ❍ No  ❍ Not sure/ Maybe

8. Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?
   ❍ Yes  ❍ No  ❍ Not sure/ Maybe

9. Do you have a prosthetic or artificial joint?  ❍ Yes  ❍ No  ❍ Not sure/ Maybe

10. Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?  ❍ Yes  ❍ No  ❍ Not sure/ Maybe

11. Have you ever had hepatitis, jaundice, or liver disease?  ❍ Yes  ❍ No  ❍ Not sure/ Maybe

12. Do you have a bleeding problem or bleeding disorder?  ❍ Yes  ❍ No  ❍ Not sure/ Maybe

13. Have you ever been hospitalized for any illnesses or operations? If yes, please explain.
   ❍ Yes  ❍ No  ❍ Not sure/ Maybe

14. Do you have or have you ever had any of the following? Please check.
   ❍ Chest pain, angina  ❍ Rheumatic fever  ❍ Pacemaker
   ❍ Seizures (epilepsy)  ❍ Heart attack  ❍ Mitral valve prolapse
   ❍ Diabetes  ❍ Kidney disease  ❍ Stroke, TIA
   ❍ Stomach ulcers  ❍ Thyroid disease  ❍ Shortness of breath
   ❍ Cancer  ❍ Arthritis  ❍ Drug/alcohol/cannabis use or dependency
   ❍ Steroid therapy  ❍ Lung disease  ❍ Tuberculosis
   ❍ Osteoporosis  ❍ Heart murmur

15. Are there any conditions or diseases not listed above that you have had? If yes, please explain.
   ❍ Yes  ❍ No  ❍ Not sure/ Maybe
16. Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer, or heart disease)?
  ○ Yes  ○ No  ○ Not sure/ Maybe

17. Do you smoke or chew tobacco products?  ○ Yes  ○ No  ○ Not sure/ Maybe

18. Are you nervous during dental treatment?  ○ Yes  ○ No  ○ Not sure/ Maybe

19. Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?
  ○ Yes  ○ No  ○ Not sure/ Maybe

20. Do you identify as a patient with a disability? If yes, please explain.
  ○ Yes  ○ No  ○ Not sure/ Maybe

_________________________  __________________________
Patient/Parent/Guardian Signature:  Date:

_________________________  __________________________
Dentist Signature:  Date:

General Release: I, the undersigned, understand that in information contained in the medical and dental history is important to my treatment. I certify that all information I have completed is correct and that I have not knowingly omitted data. I consent to the release of the medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostics procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for the dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures. To the best of my knowledge, the above information is correct:

_________________________  __________________________
Patient/Parent/Guardian Signature:  Date:

_________________________  __________________________
Dentist Signature:  Date: