DR. VITO GALLUCCI, B.Sc., B.ED.

In order to provide safe dental care for our patients, we are asking you to fill out the following questionnaire. Please answer the questions as accurately as you can. If you have any questions or doubts, check the not sure/maybe choice. Your responses will be reviewed with you by the dentist. You can be assured that the information that you provide will be kept in the strictest confidence.

Dr. Mr. Mrs. (please circle one)
Ms. Mstr. Miss

Date: _____

Name: _____ Date of Birth: _____ (Month \ Day \ Year)

Address: _____ (street) (City) (postal code)

Phone#: _____ Bus.#: _____ Cell#: _____

Occupation: _____ Employer: _____

Person to contact in case of emergency: _____ Tel#: _____ Relationship: _____

If the above is a minor, please indicate parents' full name _____

Person responsible for your dental investment: Self ☐ Other ☐ Name: _____

Do you have dental insurance? ____ (yes) \ ____ (no) Ins. Co. Name/Policy#: _____

Whom may we thank for referring you to our office? _____

Family Physician: _____

	YES	NOT SURE/ MAYBE	NO
➢ Are you being treated for any medical condition at the present or have you been treated within the last year?	☐	☐	☐
➢ When was your last medical check-up? _____			
➢ When was your last visit to a physician? _____			
Please give reason. _____			
➢ Has there been any change in your general health in the past year?	☐	☐	☐
➢ Are you taking any medications or non-prescription drugs of any kind? If the answer is yes, please list them below. _____	☐	☐	☐
➢ Do you have any allergies? _____	☐	☐	☐
➢ Have you ever had a peculiar or adverse reaction to any medicines or injections? (e.g. penicillin, aspirin or local anaesthetics, dental freezing)	☐	☐	☐
➢ Do you have any heart or blood pressure problems?	☐	☐	☐
➢ Do you have a heart murmur or mitral valve prolapse?	☐	☐	☐
➢ Have you ever had rheumatic fever?	☐	☐	☐
➢ Do you have or have you ever had jaundice, hepatitis or liver disease?	☐	☐	☐
➢ Have you ever been told that you should not give blood?	☐	☐	☐
➢ Do you have any conditions that could affect your immune system e.g. AIDS, HIV positive, leukemias, etc.?	☐	☐	☐
➢ Do you have a tendency to bruise easily or bleed for a prolonged period of time after being cut?	☐	☐	☐
➢ Have you ever been hospitalized for any serious illnesses or operations?	☐	☐	☐
➢ Do you have or have you ever had any of the following: Please tick off only those that apply.	☐	☐	☐

☐ chest pain ☐ bronchitis ☐ tuberculosis ☐ arthritis ☐ heart attack ☐ emphysema ☐ prosthetic joint
☐ epilepsy ☐ diabetes ☐ stroke ☐ asthma ☐ stomach ulcers ☐ kidney disease ☐ drug/alcohol dependency

- Are there any conditions or diseases not listed above that you have or have had? If you answered "yes", please list them. _____
- Do you smoke or chew tabacco? ☐ Yes ☐ No
- For women only: Are you pregnant? ☐ Yes ☐ No Due Date: _____
- Follow-up information to above questions: _____
- Previous Dentist: _____
- When was your last dental visit? _____
- When did you last have dental x-rays? _____
- How often do you brush your teeth? _____
- How often do you floss your teeth? _____

	YES	NOT SURE/ MAYBE	NO
Have you been seeing a dentist regularly?	☐	☐	☐
Do any of your teeth ache?	☐	☐	☐
Have you ever been advised to take antibiotics before dental appointments?	☐	☐	☐
Do your gums bleed when you brush?	☐	☐	☐
Do you have any pain when you chew?	☐	☐	☐
Do you feel that you have bad breath?	☐	☐	☐
Have you ever been in a vehicle accident or experienced any blows to your jaw?	☐	☐	☐
Have you ever had any implant surgery in one or both of your jaws or jaw joints?	☐	☐	☐

- If you answered "yes", to the last question, who performed the surgery and when was it done? _____
- Are you being followed-up by a dental specialist? _____
- Please list anything else not mentioned above regarding your past dental history. _____

I authorize release, to my insurance company/plan administrator, the information contained in claims submitted electronically.
To the best of my knowledge, the above information is correct.

_____ _____ _____ _____

(signature of patient/guardian) (date) (Reviewed by treating dentist.) (date)

Office Use Only

Extra oral: _____ TMJ: _____ Pain: _____ Left: _____ Right: _____

Intra oral: _____ Muscles: _____

Soft Tissue: _____ Oral Cancer check: _____

Smoker: ____ (yes) ____ (no) Drinker: ____ (yes) ____ (no)

Occlusion Class: _____ Overbite: _____ Overjet: _____ Crossbite: _____

Overall Oral Hygiene: Poor: _____ Fair: _____ Good: _____ Excellent: _____

General Comments: _____

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 collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Dr Vito Gallucci acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- 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 protocols comply with privacy legislation, standards of our regulatory body, the Royal College of Dental Surgeons of Ontario, and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality dental care.

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

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

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 health-care 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 health-care 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 patients' charts and records to the Royal College of Dental Surgeons of Ontario 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 patients' 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

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 that are 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 of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you 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 Dr Vito Gallucci can collect, use and disclose personal information about (patient name)_____as set out above in the information about the office's privacy policies.

_____	_____
signature	print name
_____	_____
date	signature of witness