Patient Registration Form

Your Child

Today's Date:____________

First Name:________________ Middle: ____________ Last Name:____________________

Nickname: ___________________ Gender: ▫ M ▫ F Birthdate : _____________

Address: ____

City: ____________________________ Province:_____ Postal Code:________________

Cell #:(____)________________________

How did you hear about our office?____

Parental Information (Please fill out for both parents)

▫ Mother ▫ Father ▫ Stepmother ▫ Stepfather ▫ Guardian

First Name:________________ Middle: _____________ Last Name:____________________

Preferred Name: ___________________________

Marital Status: ▫ Married ▫ Divorced ▫ Separated ▫ Single ▫ Widowed

Birthdate : ______________

Email: ____

Employer: ________________________ Occupation: ______________________________

Cell #:(___)_____________ Work #:(___)________________

What is the best way to contact you? _______________________________

Home #:(___)_____________

Address(if different from above):____

City: ____________________________ Province:______ Postal Code:_______________

Parental Information(Please fill out for both parents)

▫ Mother ▫ Father ▫ Stepmother ▫ Stepfather ▫ Guardian

First Name:________________ Middle: _____________ Last Name:____________________

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Marital Status: ▫ Married ▫ Divorced ▫ Separated ▫ Single ▫ Widowed

Birthdate : ______________

Email: ____

Employer: ________________________ Occupation: ______________________________

Cell #:(___)_____________ Work #:(___)________________

What is the best way to contact you? _______________________________

Home #:(___)_____________

Address(if different from above):____

City: ____________________________ Province:______ Postal Code:_______________

Your Child's Dental History

Date of last visit to Dentist: ___________________
For what service(Cleaning, emergency, filling etc): _________________________________
Date of last dental x-rays: ____________________
Have they complained of any dental problems, explain: ▢ Y ▢ N
____
Any unhappy dental experiences, explain: ▢ Y ▢ N
____
Any dental habits-Thumb sucking, pacifier etc. : ____________________________________
Do they brush daily ▢ Y ▢ N
Is dental floss used ▢ Y ▢ N
Do they take any fluoride supplementation ▢ Y ▢ N
Child's attitude towards Dentistry: ____

Authorizations for Treatment

I hereby authorize the dentists and staff at Children's Dental Healthcare to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment when necessary, as the standard of care to properly diagnose and record any and all dental conditions(please cross out any treatment that you do not want performed). I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance and all late payment service charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Children's Dental Healthcare. This consent is to remain in effect from the date indicated until cancelled in writing.

Signature: X_____________________________________ **Date:**____________

Relationship to Child______________________________________

Health History Form

Today's Date: ___________

Child's Name: ________________________________ Birth Date:____________________

Family Physician: ____________________ Phone: _______________City:_____________

Your Child's Medical History

Is your child currently under the care of a physician? Explain ▢ Yes ▢ No

___

Is your child taking any medications(prescription or over the counter)? ▢ Yes ▢ No

___

___

Has your child had any excessive bleeding when cut? ▢ Yes ▢ No

___

Is your child allergic to any medications or products(Ex penicillin, latex etc) ▢ Yes ▢ No

___

___

Has your child ever been seriously sick, hospitalized or had surgery? Explain ▢ Yes ▢ No

___

___

Does your child have any physical, mental or emotional disabilities? ▢ Yes ▢ No

___

___

Is your child pregnant? ▢ Yes ▢ No

Has your child had or do they now have any problems with the following?

▢ Anemia ▢ Asthma ▢ Bleeding disorders ▢ Cancer ▢ Cerebral Palsy
▢ Diabetes ▢ Ear infection ▢ Epilepsy/Seizures ▢ Fainting ▢ Hearing
▢ Heart ▢ Hepatitis ▢ HIV/AIDs ▢ Kidney ▢ Liver
▢ Sickle Cell ▢ Thyroid ▢ Tobacco Use Other________________________

___

Please describe any current or past medical treatments including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not mentioned:

___

___

May we request the release of your child's medical records if needed ▢ Yes ▢ No

COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Privacy of your personal health information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients.

In this office, Dr. Hooman Arjomand is the contact person for personal health information related matters.

All staff members who come in contact with your personal health 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 and/or your child;
- we only share your information with your consent;
- storage, retention and destruction of your personal health 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 and or your child receive the best quality dental care.

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

Our office understands the importance of protecting your personal health 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 personal health 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

You may withdraw your consent for use or disclosure of your personal health information at any time.

Patient Consent

I have reviewed the above information that explains how your office will use my (or my child's) personal health information, and the steps your office is taking to protect my or my child's information.

I agree that Dr. Hooman Arjomand and Children's Dental Healthcare can collect, use and disclose personal health information about myself and/or my child as set out above in the information about the office's privacy policies.

Signature: X____________________________Date: _________________________

Email Consent

In an effort to improve our communication with our patients, we would like to send some of our communications to you through emails, texts or social media. To comply with the Canadian Anti-Spam Legislation (CASL) our dental office would like to have your express consent to communicate in this manner. If you decide to opt in and continue receiving emails, please know that you may opt out at any time and withdraw your consent.

Please sign below to give us permission or cross out any part you would like to decline:

Yes, I consent to our family receiving information via emails, texts and/or social media from Children's Dental Healthcare :

Signature: X______________________