Confidential Patient Information and Medical History

Name: _____ Date of Birth (dd/mm/yyyy): _____
Home Address: _____
City: _____ Postal Code: _____
Home Telephone: _____ Cell Phone: _____
Best Number to Contact You: _____
Email Address: _____ Marital Status: _____
Employer: _____ Occupation: _____

Would you prefer an email or text message for appointment related correspondence? ☐ Text ☐ Email

Emergency Contact Name: _____
Relationship: _____ Phone Number: _____

General Dentist Name: _____ Referred By: _____

Do you have dental insurance? ☐ Yes ☐ No

Family Physician Name: _____ Phone Number: _____
Pharmacy:_____ Phone Number:_____

When was your last physical exam? _____ Are you in good health? ☐ Yes ☐ No

Has there been any changes to your health in the last year? ☐ Yes ☐ No

If yes, please elaborate: _____

Have you received the Covid-19 vaccine?

☐ Yes - Fully Vaccinated ☐ Yes - Partially Vaccinated ☐ No ☐ Prefer not to answer

Has it ever been recommended that you have antibiotic coverage before surgery or dental treatment?

☐ Yes ☐ No

Are you allergic or have you reacted adversely to any of the following?

	Yes	No		Yes	No		Yes	No
Aspirin			Codeine or other narcotics			Latex gloves		
Penicillin			Sedatives or sleeping pills			Other Antibiotics		
Tetracycline			Local anesthetics					

Other allergies (please list):_____

Do you smoke? ☐ Yes ☐ No Are you a former smoker? ☐ Yes ☐ No

If yes to either above, which product(s) do/did you smoke? (Circle) cigarettes/vape/cannabis/other _____
How often do/did you smoke? If cigarettes, please indicate number per day_____
How many years have/did you smoke(d)? _____
If you are a former smoker, how long ago did you quit? _____

Do you drink alcohol? ☐ Yes No

If so, how many servings per week?_____

Dental History

When was your last professional dental cleaning? _____

How often do you go for dental cleanings? _____

Has there ever been a major lapse of more than 5 years in your dental care? ☐ Yes ☐ No

If so, why?: _____

Do you have a history of:

- ☐ Previous periodontal therapy: _____
- ☐ Family history of periodontal disease: _____
- ☐ Orthodontic treatment: _____
- ☐ Other relevant dental history: _____

Home Care Routine

What type of toothbrush do you use? ☐ Manual ☐ Electric

How often do you brush your teeth per day? _____

What type of interdental aides do you use?

- ☐ String Floss ☐ Interdental Brushes ☐ Floss Piks ☐ Soft Piks ☐ Water Pik ☐ None
- ☐ Other: _____

Do you report any of the following symptoms?

- ☐ Bleeding
- ☐ Red, Swollen, or Receding gums
- ☐ Dry Mouth
- ☐ Sensitivity to ☐ Temperature ☐ Dental Cleaning
- ☐ Bad Taste
- ☐ Bad Breath
- ☐ Loose Teeth
- ☐ Shifting Teeth
- ☐ Other: _____

Do you wear a night guard? ☐ Yes ☐ No

If so, for how long? _____

Do you currently have or have you ever had any of the following conditions?

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Tuberculosis			Yellow Jaundice		
Heart Trouble			Hayfever			Leukemia		
Angina Pectoris			Sinus Troubles			HIV (AIDS)		
Mitral Valve Prolapse (MVP)			Diabetes or Excessive Thirst			Venereal Disease		
Heart Murmur			Arthritis			Cold Sores		
Artificial Heart Valve			Cancer			Drug Addiction		
Heart Attack or Surgery			Osteoporosis			Fainting		
Anemia			Sleep Apnea			Eating Disorders		
Excessive Bruising			Artificial Joint			Psychiatric Care		
Thyroid Disease			Kidney Trouble			Epilepsy/Seizures		
Hemophilia or Blood Transfusions			Stomach Ulcer			Alcohol Dependency		
Persistent Cough			Glaucoma			Stroke		
Emphysema/Bronchitis			Liver Disease			Rheumatic/Scarlet Fever		
Asthma			Hepatitis A/B/C			Other		

If other, please explain: _____

	Yes	No	Please elaborate if necessary:
Have you ever been hospitalized? If so, why?			
Are there any medical conditions that run in your family?			
Have you ever had abnormal bruising or bleeding associated with previous extractions, surgery, or injuries?			
Have you ever had any serious complications with previous dental treatment?			
Women only: Are you pregnant or currently nursing?			

Are you willing to spend 15 minutes a day to keep your teeth for a lifetime? ☐ Yes ☐ No

On a scale of 1 to 5, how nervous are you about dental treatment? (*Please circle*) 1 2 3 4 5

On a scale of 1 to 5, what is your level of stress? (*Please circle*) 1 2 3 4 5

On a scale of 1 to 5, how healthy is your diet? (*Please circle*) 1 2 3 4 5

I understand the above information is necessary to provide me with dental care. I have answered all questions truthfully and to the best of my knowledge. I consent to your obtaining from other practitioners who are currently treating or have treated me such further information as may be necessary for providing me with proper care.

Signature:_____ Date:_____

Please be advised that our office policy is not to accept assignment of benefits as payment for accounts.

Medication List

Name:_____ Date:_____

Please include all prescription and non-prescription medications.

Medication Name	Dose	Frequency

If you are unable to fill out this form, please bring your medication bottles with you to your appointment so that we can assist you in completing this information. Alternatively, with your permission, we can call your pharmacy to request a list of your current medications.

Supplement List & Tea Intake Questionnaire

Name:_____ Date:_____

Supplement	Dose	Brand	Frequency	Duration
B Vitamin Complex				
Calcium				
Chondroitin				
Echinacea				
Fish Oil (DHA, EPA)				
Omega 3, 6, 9				
Cod Liver Oil				
Flaxseed (ground)				
Flaxseed (meal)				
Flaxseed oil				
Folic Acid (Folate)				
Glucosamine				
Iron				
Lycopene				
Magnesium				
Multivitamin/ Multimineral				
Probiotic				
Protein “scoop”				
Vitamin B6				
Vitamin B12				
Vitamin C				
Vitamin D (D2/D3)				
Vitalux (For eye health)				
Zinc				
Other:				

CDAnet Patient Information Form- Insurance Information

Is this an accident claim? ☐ Yes ☐ No

Accident Claim Number:_____

PRIMARY INSURANCE INFORMATION

Name of Patient:_____
Name of Policy Holder:_____
Policy Holder's Date of Birth (dd/mm/yyyy):_____
Insurance Company:_____
Policy/Group Number:_____
Subscriber/Certificate Number:_____
Place of Employment:_____

Relationship of patient to policy holder: ☐ Self ☐ Dependant ☐ Spouse

Are you claiming from more than one insurance company? ☐ Yes ☐ No
If yes, please complete the following:

SECONDARY INSURANCE INFORMATION

Name of Patient:_____
Name of Policy Holder:_____
Policy Holder's Date of Birth (dd/mm/yyyy):_____
Insurance Company:_____
Policy/Group Number:_____
Subscriber/Certificate Number:_____
Place of Employment:_____

Relationship of patient to policy holder: ☐ Dependant ☐ Spouse

AUTHORIZED CONSENT TO RELEASE INFORMATION

I authorize release to my dental benefits plan administrator, information contained in claims submitted electronically.

I also understand that the office of Dr. Peter Fritz and Dr. Luisa Schuldt is a non assignment office, meaning that all reimbursement cheques will be sent to the insurance subscriber, and that I am personally responsible for payment of my account.

Signature of Patient/Parent/Guardian: _____

Date: _____

Patient Consent for the Office Privacy Policy

For Collection, Use and Disclosure of Personal Information
We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We are as open and transparent as possible about the way that we handle your personal information.

In this office, Dr. Fritz 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. All staff members are trained in the appropriate uses and protection of your information.

In this document, we have outlined what our office is going to ensure that:

- Only absolutely necessary information is collected
- We only share your information with your other health care providers with your consent
- Storage, retention and destruction of your personal information complies with current 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 (RCDSO) and the law.

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

This office will collect, use and disclose information for the following purposes:

- To deliver safe and efficient patient care;
- To assess your health needs and advise you of treatment options;
- To establish and maintain communication with you;
- To allow us to efficiently follow-up for treatment, care, and finances;
- To complete and submit dental claims for third party adjudication and payment;
- To comply with legal and regulatory requirements, including the delivery of patient information and records to the RCDS(O) in a timely fashion, when required, according to the provisions of the Regulated Health Professionals Act;
- To comply with agreements/undertakings entered into voluntarily by the member with the RCDSO, including the delivery and/or review of patient information and records to the College in a timely fashion for regulatory and monitoring purposes;
- To deliver information 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 comply with all regulatory requirements and the law.

By signing below, I have agreed and given my informed consent to the collection, use and/or disclosure of my personal information for the purposes listed above. If a new purpose arises for the use and/or disclosure of my personal information, we will seek your approval and permission 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 RCDSO fulfilling its mandate under the RHPA, and for the defence of a legal issue.

Our office will not under any condition supply your insurer with your confidential medical history. In the event that a request of this nature 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 the use or disclosure of your personal information, and we will explain the ramifications of that decision and the process.

Cancellation & Re-Scheduling Policy

Our goal is to provide exceptional and timely service to all of our patients. If you must make a change to your appointment, we encourage you to let us know at least **two (2) business days** (Monday-Friday) prior to your scheduled appointment to avoid a cancellation or re-scheduling penalty.

If you must make a change to your *appointment that requires sedation,* we encourage you to let us know at least **one (1) week** prior to your scheduled appointment with one of our Registered Nurses to avoid a cancellation or re-scheduling penalty.

Should you need to *re-schedule* your upcoming appointment within a **2 business day** window (1 week for appointments requiring sedation), you will be subject to a $400 cancellation fee in addition to needing to pre-pay for your next appointment.

I have reviewed the *Office Privacy Act* that explains how Dr. Peter C. Fritz Periodontal Wellness and Implant Surgery will use my personal information and the steps this office is taking to protect my information.

I know that the office has a Privacy Code and I can ask to see the Code at any time.

I agree that Dr. Fritz and Dr. Schuldt can collect, use and disclose personal information about me as set out in the information about the office's privacy policies.

I have reviewed the Cancellation and Re-Scheduling Policy and agree to the terms and conditions.

Patient Name	Authorized Witness Name
Patient and/or Authorized Substitute Signature	Authorized Witness Signature
Date	