

Patient Privacy Consent Form For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality 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, as it is important for us to provide this service to our patients.

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.

In 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 protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body as well as the law.

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

Please be assured that every staff member in our office is committed to ensuring that you receive the best quality 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 how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following reason;

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality care
- To assess your health and needs
- To provide health care
- To advise you of treatment options, care, and services
- To communicate with our treating health-care providers including specialists and referring 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 with treatment care, invoice for good and services, as well as collect funds for past and present treatment.
- For teaching and demonstrating purposes on anonymous basis
- To complete and submit claims for third party adjudication and payment
- To comply with legal and regulatory requirements including the delivery of patients' charts and records to governing bodies 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 governing bodies, including the delivery and/or review of patients' charts and records in a timing fashion for regulatory and monitoring purposes.

- To permit potential purchasers, practice brokers or advisers to evaluate the practice or conduct an audit in preparation for a practice sale.
- To deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages if any.
- To prepare materials for the Health Profession and Appeal Review Board.
- 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 or the use and or disclosure of your personal information, we will seek your approval in advance.

Your information may be assessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any condition, supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly for you to review and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We will also advise you if such a release is appropriate.

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 explained 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. Keith Compton can collect, use and disclose personal information as set out above in the information about the office's privacy policies.

Signature _____ Print Name _____

Date _____ Signature of Witness _____



WELCOME TO THE OFFICE OF DR. KEITH COMPTON

Mr./ Mrs.
NAME: Ms./Miss _____ DATE: _____
Dr. Last First

ADDRESS: _____
Street City Province Postal Code

HOME PHONE: _____ WORK PHONE: _____

FAX NUMBER: _____ CELL PHONE NUMBER: _____

E-MAIL: _____

OCCUPATION: _____

DATE OF BIRTH _____ AHC# _____
Day Month Year

WHO REFERRED YOU TO OUR OFFICE? _____ PHONE # _____

WHAT IS THE MAIN REASON YOU HAVE BEEN REFERRED TO OUR OFFICE FOR CARE?

1. DENTAL INSURANCE COVERAGE – IS THIS YOUR PLAN? _____

NAME OF INSURANCE HOLDER: _____ DATE OF BIRTH: _____

NAME OF INSURANCE COMPANY: _____

GROUP# _____ SEC/DIV: _____ I.D.# _____

ARE YOU COVERED BY A SECOND INSURANCE PLAN? IF SO, PLEASE GIVE THE SAME INFORMATION AS ABOVE.

NAME OF INSURANCE HOLDER: _____ DATE OF BIRTH: _____

NAME OF INSURANCE COMPANY: _____

COMPANY NAME OF EMPLOYER: _____

GROUP# _____ SEC/DIV: _____ I.D.# _____

2. IS THIS A MEDICAL/LEGAL CASE? _____ IF SO, PLEASE GIVE THE FOLLOWING:

LAWYER'S NAME: _____ PHONE NUMBER: _____

ADDRESS: _____

WE REQUIRE YOUR DENTAL INSURANCE INFORMATION FOR PRE-DETERMINATIONS ONLY. YOU ARE DIRECTLY RESPONSIBLE TO OUR OFFICE FOR ALL CHARGES INCURRED IN THIS OFFICE. WE DO NOT DIRECT BILL.

OFFICE USE ONLY:

MEDICAL ALERT: _____

PATIENT RECORDS

MEDICAL HISTORY:

1. Are you presently under a physician's care? Yes No

If yes, what is your physician's name? _____

2. Are you presently taking any medications? Yes No

If yes, what medication and what is the dosage? _____

3. Are you allergic to any medications? Yes No

If yes, what medication are you allergic to? _____

4. Have you ever had a serious illness or operation? Yes No

If yes, please list: _____

5. Have you ever had any abnormal bleeding problems? Yes No

If yes, explain: _____

6. Please check any of the following medical conditions:

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma/Emphysema/Lung Problem |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Glaucoma/Other Eye Problem |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Tumors/Growth | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> AIDS (HIV) or a risk of exposure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Tested Positive for AIDS |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Hip/Joint Replacement | <input type="checkbox"/> None of the above |

7. If you have checked off any of the illnesses listed on the previous page, please expand on dates and the treatments given: _____

8. Have you ever been hospitalized with any serious illnesses? Yes No
If yes, give reasons: _____

9. Do you use tobacco in any form? _____ Yes No
10. Do you take drugs, medically prescribed or otherwise? Yes No
11. Have you been treated by a psychologist or a psychiatrist in the past for stress management? Yes No
12. In your estimation, do you handle stress well? Yes No
13. Would you consider your personal or professional lifestyle stressful? Yes No
14. Is there any other information about your health that our office should know about? _____

15. For women only: Are you pregnant? Yes No
If so, what is your due date? _____

DENTAL HISTORY:

1. Please give the name, address, and telephone number of your general dentist: _____

When was your last dental visit? _____
What was done? _____
When were your last dental x-rays taken? _____
Have you had specific x-rays of your TMJ (jaw joints)? _____
2. Are you having any specific dental pain? Yes No
3. Have you had any treatment for your TMJ (joint) pain? Yes No
If yes, list the practitioners treating you: _____

4. Are you aware of gum disease (periodontal) problems in your mouth? Yes No
- Have you ever had periodontal treatment? Yes No

5. If yes, what is the name of your periodontist and the date of your last treatment? _____

6. Have you ever been told that you have TMD (jaw joint) problems? Yes No
- If yes, when? _____ By whom? _____

7. Do you notice popping or clicking in your jaw? Yes No
- Do you notice soreness in your jaw? Yes No
- Do you notice pain in your jaw? Yes No
- If yes to any of the above, is it on the right side or the left side? _____

8. Do you brush daily? Yes No

9. Do you floss daily? Yes No

10. Have you had any problems with dental freezing (local anesthetic)? Yes No

11. Have you been prescribed pre-medications prior to dental appointments? Yes No

If yes, which medication was prescribed? _____

The information above is correct to the best of my knowledge.

Print Name: _____

Signature: _____ Date: _____

I authorize the taking of oral photographs during diagnosis, treatment and subsequent recare appointments. The photographs will be used in the most dignified manner for the purpose of patient and dental education in presentations, lectures, and scientific papers.

Signature: _____ Date: _____

If Dr. Compton feels it is necessary to be treated by another practitioner, I authorize that my records in whole or part may be transferred to that practitioner.

Signature: _____ Date: _____