

Patient and Contact Information

Patient Information

Title: Mr. Mrs. Ms. Miss Dr. Master Mx.

First Name _____

Middle Name _____

Age _____

Last Name _____

Date of Birth _____

_____/_____/_____
Day Month Year

Address _____

City _____

Province _____

Postal Code _____

Contact information

Which are the TWO (2) BEST phone numbers that we may reach you 1-2 days prior to your appointment:

Who's Phone Is This?

Their Name (if not you)

	Patient	Mother	Father	Spouse	Son	Daughter	Other	
Cell Phone 1 ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cell Phone 2 ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Home Phone ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Email address _____

Yes No thanks

May we text or email you for feedback and comments?

Insurance Information

How many dental insurance plans are you covered under?

None One Two Three

Insurance Policy Information

Insuring Agency _____

Policy # _____ Division _____

Subscriber Name _____

Subscriber Date of Birth _____/_____/_____
Day Month Year

Certificate # or ID _____

Employer _____

Co-Insurance Policy Information

Insuring Agency _____

Policy # _____ Division _____

Subscriber Name _____

Subscriber Date of Birth _____/_____/_____
Day Month Year

Certificate # or ID _____

Employer _____

Referral Information

Which dentist referred you to our office? Dr. _____ (City _____)

If none of the above, how did you hear about us? _____

Health Information

Health Card (Adults Only): _____ Version _____

Family Physician: Dr. _____ Phone: (_____) _____ Location _____



Name: Last _____
First _____

Pre-Anesthesia Questionnaire (Adult)

Yes	No	Maybe Not sure
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1. Do you have any health problems or illnesses presently? Yes No Maybe Not sure
 IF YES, Please list: 1. _____ 3. _____
 2. _____ 4. _____
2. Has there been ANY CHANGE in your health in the past 12 months? Yes No Maybe Not sure
 IF YES, Please explain: _____
3. Have you ever been in hospitalized for an illness? Yes No Maybe Not sure
 IF YES, please explain _____
4. Have you ever had general anesthesia previously? Yes No Maybe Not sure
 IF YES, 1. Year _____ Reason _____ Any problems? _____
 2. Year _____ Reason _____ Any problems? _____
4. Have you or any of your family relatives had problems during an anesthetic? Yes No Maybe Not sure
 IF YES, 1. Please explain _____
 2. Were any tests done? _____
5. Do you have a drug allergy? Yes No Maybe Not sure
 If YES, 1. What drug? _____ What happens? _____
 2. What was done to treat it _____
6. Do you have other allergies? Yes No Maybe Not sure
 IF YES, please list 1. _____ What happens? _____
 2. _____ What happens? _____
7. Do you take ANY medications right now (including puffers and birth control pills)? Yes No Maybe Not sure
 IF YES, please list Name, dose, and reason for taking
 1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____
8. Do you use or take ANY non-prescription remedies ? Yes No Maybe Not sure
 IF YES, please list 1. _____ 2. _____
9. Have you taken a cortisone (steroid) type drug orally in the past year? Yes No Maybe Not sure
 IF YES, for what reason? _____ For how long? _____
10. Do you or any of your relatives have a bleeding problem? Yes No Maybe Not sure
12. Have you ever had an excessive amount of bleeding following surgery such as tooth extraction? Yes No Maybe Not sure
13. Do you get frequent nose bleeds (such as every week)? Yes No Maybe Not sure
14. Do you snore at night or been told that you do? Yes No Maybe Not sure
15. Do you know if you have obstructive sleep apnea? Yes No Maybe Not sure

16. Do you have or have you ever had any of the following?

	Don't know				Maybe		
	Yes	No	Not sure		Yes	No	Not sure
Heart murmur	___	___	___	Asthma	___	___	___
Heart attack	___	___	___	Tuberculosis	___	___	___
Chest pain or angina	___	___	___	Emphysema	___	___	___
Shortness of breath lying down	___	___	___	Epilepsy	___	___	___
Swollen Ankles	___	___	___	Seizures or convulsions	___	___	___
Heart pacemaker	___	___	___	Stroke	___	___	___
Irregular heart beat or arrhythmia	___	___	___	Fainting Spells	___	___	___
High blood pressure	___	___	___	Diabetes	___	___	___
Congenital heart disease	___	___	___	Thyroid problems	___	___	___
Damaged/abnormal heart valves	___	___	___	Adrenal gland problems	___	___	___
Rheumatic Fever	___	___	___	Hepatitis	___	___	___
Kidney Disease	___	___	___	Jaundice	___	___	___
Artificial joints	___	___	___	Liver disease	___	___	___
HIV, AIDS, or an STD	___	___	___	Gastroesophageal Reflux	___	___	___
Anemia (including sickle cell)	___	___	___	Stomach ulcers/bleeding	___	___	___
Malignant hyperthermia	___	___	___	Arthritis	___	___	___

WOMEN:			
Are you pregnant?	___	___	___
Are you a nursing mother	___	___	___
Do you have problems associated with your menstrual cycle?	___	___	___

- | | Yes | No | Maybe Not Sure |
|--|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you active or play sports (e.g. golf with no cart, bowling, swimming, cycling, dancing)?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| What activity or sport? _____ | | | |
| 18. Are you able to shovel snow in the winter? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Can you walk up a flight of stairs holding a bag of groceries without resting? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Can you perform light housework (dusting or vacuuming) without getting short of breath?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Can you walk a distance of 2 city blocks quickly without resting? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you ever have episodes of blurred vision, see black spots, or experience weakness or paralysis on one side of your body, arms, legs, or face? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you have any jaw joint problems (injury, surgery, arthritis) or moving your neck fully (cervical spine)?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever had surgery and/or radiation treatment for a tumour or cancer of the head/neck? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you smoke?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you drink more than five alcoholic beverages per week?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you have a history of alcoholism or drug dependence?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you taken any "recreational" drugs in the past year such as marijuana, LSD, cocaine, or crack?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have ANY disease, condition or problem not listed above?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



Signature: _____	Date: _____
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2480 Homer Watson Blvd., Unit #4A
Kitchener, Ontario N2P 2R5
Tel: (519) 896-0204
Fax: (519) 896-0205

Informed Consent For Anesthesia

Dear Parents and Patients,

We are committed to providing a safe, relaxed, and comfortable experience but we require your cooperation. Please understand that the following has been provided so that you may be informed of what is involved with having dental procedures performed under anesthesia so as to enable you to make well informed decisions concerning your, or your son or daughter's treatment, and not to make you anxious. The "Attending Doctor" referred to below are one or more of our staff Dental Anesthesiologist(s) Dr. J. Wong and/or Dr. S. Khojasteh, and/or Dr. R. Tobis, and/or Dr. S. Moshiri

Sincerely,

Dr. J. Wong, Dr. S. Khojasteh, Dr. Tobis, and Dr. Moshiri

Nursing or expectant mothers:

I understand that any medicines including some anesthetics may be harmful to an unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the Attending Doctor of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For similar reasons, I understand I must inform Attending Doctor if I am a nursing mother.

Authorization to Access Medical Records:

I hereby authorize and request Attending Doctor or authorized staff to contact persons on my behalf and obtain any previous or current medical records/information in order to properly assess my health status prior to anesthesia.

Side Effects:

I understand that the most frequent side effect of anesthesia is drowsiness and dizziness following the anesthesia such that I should not operate any motor vehicle, any hazardous device/machine, or make any important decisions for at least 24 hours or until completely recovered from the effects of anesthesia. Parents are advised of the necessity for direct parental supervision of children for 24 hours following their anesthesia. Nausea and vomiting following anesthesia is a rare occurrence seen in less than 1 percent of the time.

Use of alcohol or other medications and drugs:

Since anesthesia may cause drowsiness and incoordination which may be enhanced by use of alcohol or drugs, I have been advised to abstain from their use until completely recovered from the effects of anesthesia and prescription medicines.

Consent for Anesthesia:

I hereby authorize and request the Attending Doctor to perform anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize and request the administration of such anesthetic(s) by any route that is deemed suitable by the Attending Doctor. It is the understanding of the undersigned that Attending Doctor, along with nursing and dental assisting staff will have full charge of the dental work as well as administration and maintenance of anesthesia as a team.

I acknowledge receipt of and completely understand both pre-operative and post-operative anesthesia instructions. It has been explained to me and I accept that there is no warranty or guarantee as to any result and/or cure. I have had the opportunity to ask questions about my or my child's anesthesia and am satisfied with the information provided to me.

Patient Name _____ Signature _____ Date _____

Parent/Guardian _____ Signature _____ Date _____

Witness _____ Signature _____ Date _____

Jason K. Wong D.D.S., M.Sc., D.A.D.B.A
2480 Homer Watson Blvd., Unit #1
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Tel: (519) 896-0204
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Your Privacy is Our Concern and Responsibility

Dr. Wong and staff are committed to respecting your privacy by collecting, using, disclosing your personal information openly, transparently, and responsibly. With information related to your anesthesia care: Dr. Wong acts as the Privacy Information Officer.

- only necessary information is collected about you. and this is shared with only 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 the Royal College of Dental Surgeons of Ontario.

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

Dr. Wong will collect, use, and disclose information about you for the following purposes:

- to assess your health status to determine if you may need medical investigation prior to, during, and after undergoing an anesthetic
- to enable us to contact and maintain communication with you to book, confirm appointments, and to distribute health-care information
- to advise you of treatment options, pre-operative instructions and to allow efficient post-treatment follow-up
- to provide treatment, care, and services in relationship to your oral and maxillofacial complex and anesthetic care
- to communicate with other physicians, medical and dental specialists, and referring/peripheral general dentists
- for teaching and demonstrating purposes on an anonymous basis
- to invoice for goods and services, for billing purposes, and for completion and submission of dental claims for third party adjudication
- for payment and processing credit card payments, and to collect unpaid accounts
- 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 to prepare materials for the Health Professions Appeal and Review Board (HPARB) and records to the College in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to conduct an audit, evaluate the dental practice in preparation for a practice sale. Also 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 assist this practice to comply with the law and regulatory requirements

By signing the consent section below, 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. 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. Jason. K. Wong can collect, use and disclose personal information about _____
as set out above in information about the office's privacy policies. (Patients Name)

Signature (Patient or Parent/Guardian)

Print Name

Date

Signature of Witness