Burin Dental Clinic
Confidential Patient Treatment Record

Surname_____ First Name_____ Middle Initial:_____
Mailing/Civic Address_____ City_____ Postal Code_____
Home Phone #_____Work Phone #_____Cell Phone#_____
Email Address_____
Date of Birth_____ MCP#_____
Occupation_____ Place of Employment_____
Family Physician_____ Previous Dentist_____
Next of Kin_____
Address_____ Phone #_____
Are you covered by dental Insurance?_____If yes, which company?_____

Confidential Medical History
DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?
Indicate with Yes/No (Y/N)

Problems with jaw joint ____
Heart Disease or high blood pressure____
Stroke or Heart Attack____
Hepatitis, Jaundice or Liver Disease____
AIDs, HIV, STIs___
Arthritis, Circulation Problems____
Tuberculosis or Other Lung Aliments____
Fainting Spells or Seizures____
Kidney or Liver Disorders____
Cancer, Chemo, or Radiation Treatment ____
Asthma, Emphysema, Hay Fever ____
Anemia or Other Blood Disorder____
Artificial Joints (Knee/Hip), Organ Transplant____
Diabetes____
Glandular Disorders____
Head/neck Injuries____
Mental/Nervous Disorders, Psychiatric Treatment____
Sinus Trouble____
Stomach/intestinal problems/Ulcers____
Allergy to Latex or Rubber___
Allergy to Drugs, Food, Local anaesthetic, etc.___ If yes, please list: _____
_____

Are you presently taking any drugs or medications? ____ If yes, please list:_____
_____

Do you have hearing difficulties?_____
Do you bleed excessively from a cut or injury, or bruise easily? _____
Do you smoke?_____
How many alcoholic beverages do you consume per week?_____
Do you use recreational Drugs? Ie. Marijuana, cocaine, etc _____
Have you been advised to take Antibiotics prior to all dental appointments?____

Confidential Dental History

Have you ever had any of the following?

Periodontal Treatment (Gum Treatment/Surgery)____

Orthodontic Treatment (Braces)____

Local Anaesthetic (Freezing)____

Oral Surgery____

Fractured Jaw____

Popping/Clicking on your jaw joints____

Difficulty opening or closing____

Do you presently have any of the following?

Loose teeth____ Bleeding Gums____ Poor Fitting Dentures____ Sensitive Teeth____ Bad Breath____

Have you been under regular care by a dentist?_____

How long has it been since your last dental visit? _____

Do you have any disease, condition, or problem not listed above? ___ If yes, please specify:_____

_____

WOMEN ONLY

Are you pregnant or suspect you may be?____

Are you taking Birth Control?____

OFFICE POLICY

In the event that you are unable to attend an appointment, we require 24 hours notice. Otherwise a charge may be made. We require that services are paid for at each visit. However, special arrangements may be agreed to upon consultation with our staff.

CONSENT FOR TREATMENT

This is to certify and consent to performing of dental procedures agreed to be necessary and advisable. I, as well, assume full responsibility for all fees associated with these procedures.

_____ _____

Patient (Parent/Guardian) Signature **Date**

PATIENT ACKNOWLEDGEMENT AND CONSENT

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we will have collected in the future.

Existing Laws requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient (Parent/Guardian) Signature Patient (Parent/Guardian) Name(please print)

_____

Date

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.