

Patient Information

Dr. Aly Adatia D.D.S 400-655 Erb Street West Waterloo, Ontario N2J 3Z4

Personal Information			
Dr. Mr. Mrs. Ms. Miss.			
Last Name:			
First Name:			Date of birth:
Address:			
City:			Postal Code:
Home Number:	Work Number:		Cell Number:
Email address:			
Is it ok that we contact you at the above contact number(s)?	Yes	No	
Financial Information			
Employer:			
Person Responsible for Account:			Relationship:
Address:			Phone Number:
Do you have dental insurance Yes	No		
Primary Insurance			
Policy Holder:			Date of birth:
Name of insurance company:			
Policy Number:			Certificate Number:
Secondary Insurance			
Policy Holder:			Date of birth:
Name of insurance company:			
Policy Number:			Certificate Number:
In case of an emergency, whom should we contact?	Name:		Phone Number:
Whom may we thank for referring you?	•		



Medical History

Patient Name:				
Physician Name:		Physician Phone Number:		
DO YOU HAVE OR HAVE YOU I	HAD:	ARE YOU:		
	miD.	40. Presently being treated for any illness	Yes No	
(circle all that apply)		41. Taking any medication regularly now		
1 D 1 '4 I' 1 C 'II	37 AT	or within the past year	Yes No	
1. Been hospitalized for illness or surgery	Yes No	42. Aware of a change in your general		
2. An allergic reaction	Yes No	health in the past year	Yes No	
3. Any reaction to:	** **	43. Aware of any recent weight change.	Yes No	
a. aspirin	Yes No	44. Often thirsty	Yes No	
b. penicillin	Yes No	45. Urinating more than 6 times per day	Yes No	
c. erythromycin	Yes No	46. Often exhausted and frustrated	Yes No	
d. tetracycline	Yes No	47. Subject to frequent headaches	Yes No	
e. codeine	Yes No	48. A smoker, if yes how much?	Yes No	
f. sedatives or sleeping pills		49. Generally a nervous person.	Yes No	
(barbiturates)	Yes No	50. Often unhappy and depressed	Yes No	
g. dental anesthetic	Yes No			
h. any other medication	Yes No	IF FEMALE, ARE YOU NOW:		
4. Hepatitis	Yes No	51. Pregnant or Nursing	Yes No	
5. Jaundice (yellow skin & eyes)	Yes No	52. Taking birth control pills or other hormones	Yes No	
6. Epilepsy	Yes No	22. Taking offer control plans of outer normones	100 110	
7. Arthritis	Yes No	Diago armiain the galacted items on	d adiaatia.	
8. Venereal disease	Yes No	Please explain the selected items an	a meaicanoi	
Rheumatic fever	Yes No			
10. Scarlet fever	Yes No	-		
Anemia or other blood disorders	Yes No			
Prolonged bleeding due to slight cut	Yes No			
Kidney disease	Yes No			
14. Diabetes	Yes No	·		
Stomach or duodenal ulcer	Yes No			
Liver disease	Yes No	-		
17. Tuberculosis	Yes No			
18. Emphysema	Yes No			
Thyroid or parathyroid	Yes No			
20. Heart trouble	Yes No			
21. Heart murmur	Yes No			
22. Arteriosclerosis	Yes No			
23. High blood pressure	Yes No			
24. Low blood pressure	Yes No			
25. Excessively swollen ankles.	Yes No			
26. A stroke	Yes No			
27. Shortness of breath on mild exertion	Yes No			
28. Chest pains on mild exertion	Yes No			
29. Hives, skin rash, hay fever	Yes No			
30. Asthma	Yes No			
31. Emotional problems or tension	Yes No			
32. Psychiatric treatment	Yes No			
33. A tumour or abnormal growth	Yes No			
34. Radiation treatment by cobalt, radium				
x-ray etc	Yes No	Daviawad hu		
35. Glaucoma	Yes No	Reviewed by:		
36. Contact lenses	Yes No	Destan		
37. Prostate disorders (if male)	Yes No	Doctor:		

Yes No

Yes No

Date:_

38. Aids or contact with HIV Virus

39. Malignant hyperthermia.



DR. ALY ADATIA PREVENTIVE DENTAL CARE PATIENT CONSENT FORM: FOR COLLECTION USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality dental 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. It is important to us to provide this service to our patients. In this office, Dr. Aly Adatia, 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. 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;
- We only share your information 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 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 members of our office staff. Please be assured that every staff person in our office is committed to ensuring that you receive the best quality dental care. Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined her how our office is using and disclosing your information. This office will collect, use and disclose 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 plans
- 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.

Patient Name:	
Patient Signature:	Date: