PATIENT INFORMATION

Today's Date: .....

Title: Ms. ○ Mrs. ○ Mr. ○ Dr. ○

First Name: ..... Middle Name: ..... Last Name: .....

Gender: Male ○ Female ○ Birth Date: ..... Age: .....

E-mail: ..... OK to e-mail you? Yes ○ No ○

Address: .....

City: ..... Province: ..... Postal Code: .....

Home Phone: ..... Mobile Phone: .....

Business Phone: ..... Occupation: .....

Preferred method to contact: .....

OHIP number: .....

Referring dentist: ..... Family Doctor: ..... Family Doctor phone #: .....

Emergency contact: ..... Relationship: ..... Their phone #: .....

If child, responsible parent/guardian: .....

DENTAL INSURANCE INFORMATION

No dental insurance ○

	Primary insurance	**Secondary insurance**
Insurance company:		
Subscriber Name:		
Subscriber DOB:		
Relationship to Subscriber:		
Employer:		
Policy #:		
Identification #:		

DENTAL HISTORY

Is anything bothering you in your mouth right now? Yes ○ No ○ .....

When was your last dental check up/cleaning? .....

Have you ever been treated by another dental specialist? Yes ○ No ○

If so, which type, for what, and when? .....

Have you ever had braces (orthodontics)? Yes ○ No ○

Have you ever been diagnosed with a temporomandibular disorder? Yes ○ No ○

How many times per day to you brush your teeth? ..... Your tongue? ..... Floss your teeth? .....

Do your gums Bleed ○ Swell ○ Hurt ○

Do any of your teeth feel loose ○ have shifted ○

Do you grind your teeth ○ clench your teeth ○

Are any of your teeth sensitive? Yes ○ No ○

Do you have a night guard ○ orthodontic retainer ○ removable complete denture ○ removable partial denture ○ dental implant(s) ○

Are you nervous about dental treatment? Yes ○ No ○

DR. SASHA STASKO

BSc, MSc, DDS, MS, Cert. Perio., FRCD(C)

PHONE: (519) 944 - 2442
FAX: (519) 944 - 1485
info@staskoperio.com

3506 Tecumseh Rd E. STE #2
Windsor, Ontario N8W 1H6
www.staskoperio.com

PATIENT MEDICAL HISTORY

Are you under the care of a physician, or have you been in the past 5 years? Yes ○ No ○ Last physical examination? .....

If yes, why? .....

Do you currently smoke? Yes ○ No ○ If yes, how many cigarettes per day? ..... For how long have you smoked? .....

Do you smoke anything else (E-cigarette, Marijuana, Pipe)? .....

Have you ever smoked? Yes ○ No ○ How long did you smoke for? ..... When did you quit? .....

Do you drink alcohol? Yes ○ No ○ If so, how much per week? ..... Any recreational drug use? Yes ○ No ○

Do you take any prescription medications, over-the-counter medications, vitamins, supplements, alternative preparations? Yes ○ No ○

If so, please list (or attach a list; please include all supplements/vitamins too):

.....

.....

Do you have any drug allergies ○ food allergies ○ latex allergy ○ environmental allergies ○

If so, please list and provide us with reaction, and time of last episode. .....

Have you had any surgeries in the past? Yes ○ No ○ If so please list. .....

Have you had any issues with healing or bleeding in the past? Yes ○ No ○

Have you ever had a joint replacement ○ a valve replacement ○ stent placement ○ infective endocarditis (an infection of the heart) ○

Have you ever been hospitalized in the past? Yes ○ No ○ If so, for what condition(s)? .....

Have you ever had cancer? Yes ○ No ○

If so, explain diagnosis and treatment including if any chemotherapy, radiation or surgery: .....

Have you ever been diagnosed with, or do you currently have DIABETES? Yes ○ No ○

If so, when were you diagnosed? ..... What is your most recent glycosylated hemoglobin (HbA1c)? .....

Have you ever had a seizure, or been diagnosed with epilepsy? Yes ○ No ○

Do you have a congenital heart defect ○ high blood pressure ○ congestive heart failure ○

Have you ever been treated for asthma? Yes ○ No ○

If so, what triggers your asthma and have you been hospitalized for asthma? .....

Have you ever been diagnosed with HIV/AIDS or hepatitis? Yes ○ No ○

Are you on blood thinners (e.g. Aspirin, Coumadin/Warfarin, Plavix, Eliquis, Xarelto)? Yes ○ No ○ .....

Are you taking or have you ever taken any bone altering medications for the treatment of osteoporosis, cancer, etc., either by mouth, injection under the skin, or intravenously? Some examples may include: Fosamax, Actonel, Zometa (bisphosphonates) or Prolia. Yes ○ No ○

How long have you been taking them? ..... Last dose? .....

Have you ever been treated with steroids? Yes ○ No ○

If female, are you pregnant or lactating? Yes ○ No ○

Have you had or been diagnosed with any of the following:

○ Heart attack	○ Jaundice	○ Gout	○ Liver disease
○ Kidney disease/problems	○ Bleeding disorder	○ Lung disease	○ Stroke/TIA
○ Thyroid disease	○ Drug/alcohol dependency	○ Chest pain	○ Angina
○ Shortness of breath	○ Tuberculosis	○ Rheumatic fever	○ Heart murmur
○ Mitral Valve prolapse	○ Anemia	○ Osteoarthritis	○ Rheumatoid arthritis
○ Lupus	○ High cholesterol	○ Artificial shunts	○ Eye problems
○ Sinusitis	○ Gastroesophageal reflux disease	○ Ulcerative colitis or Crohn's disease	
○ Sleep apnea (+/- CPAP)	○ Mental illness (e.g. depression, bipolar, anxiety, etc.)		○ Other autoimmune disease

Are there any other conditions you have or may have had in the past which are not listed above? Yes ○ No ○

Do any of the following conditions run in your family? Yes ○ No ○

DR. STASKO'S COMMENTS AND DATED SIGNATURE OF REVIEW:

DR. SASHA STASKO

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PATIENT CONSENT FORM: COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Privacy of your personal health information is an important part of our office providing you with quality dental care. We understand the importance of protecting your personal health information. We are committed to collecting, using and disclosing your personal health information responsibly. We also try to be as open and transparent as possible about the way we handle your personal health information. It is important to us to provide this service to our patients.

In this office, Dr. Sasha Stasko is the contact person for personal health information related matters.

All staff members who come in contact with your personal health 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 health 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 member of our office staff.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL HEALTH INFORMATION

Our office understands the importance of protecting your personal health information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose personal health 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 options
- 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
- 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 records to the College in a timely fashion for regulatory and monitoring purposes
- to permit potential purchasers, practice brokers or advisors to evaluate the dental practice
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- 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 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 assist this office to comply with all regulatory requirements
- to comply generally with the law

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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 health information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal health information, we will seek your approval in advance.

Your personal health 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.

You may withdraw your consent for use or disclosure of your personal health information at any time.

By signing the consent section you also agree that all the information you provided either in writing or verbally to Dr. Sasha Stasko and or her staff is correct and true.

PAYMENT POLICY

Full payment is due at time service is rendered unless other arrangements have been made in advance. For your convenience we accept Visa, MasterCard, American Express, Debit, Cash or cheque. Although we will help send the relevant information to insurance companies, all quotes are provided for informational purposes only.
The patient themselves is fully responsible for all fees charged by this office regardless of your insurance coverage.

CANCELLATION POLICY

We kindly ask patients to give 48 hours notice if they are unable to attend an appointment. If a patient misses an appointment without proper notice, a cancellation fee will be charged.

PATIENT CONSENT

I have reviewed the above information

- That explains how your office will use my personal health information.
- The steps your office is taking to protect my information.
- That the information I have provided is correct and true.
- That is is my responsibility to inform Dr. Stasko if my information changes.
- That I understand the office payment and cancellation policies.

I agree that Dr. Stasko can collect, use and disclose

personal health information about _____
[Patient Name]

as set out above in the information about the office's privacy policies.

Signature _____ Date _____

Print name _____ Signature of witness _____

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