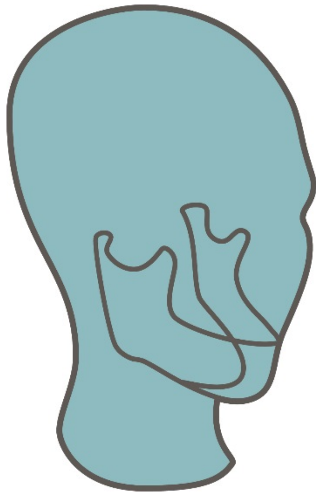

ClinicOMS

Oral & Maxillofacial Surgery

VAUGHAN

DIGITAL PATIENT CARE PACKAGE

WELCOME BACK

There is no better time to be diligent and cautious for the safety and well-being of our community. For this reason, ClinicOMS is taking all possible measures to keep us all safe, without compromising your level of care. In an effort to help you understand some of the changes you will experience, we have provided you with this Digital Patient Care Package. After reading it in its entirety, feel free to contact our patient care coordinators with any questions you may have.

VISITING OUR CLINIC

Our clinic will appear and feel a little different during this pandemic. We have made some precautionary changes to our physical space as well as our usual patient care protocols. This is not only to enable us to continue to provide you with the level of care you deserve, but to also ensure your safety and the safety of our team and our families.

Appointment Times

We are limiting the number of patients we see in a day to enable us to uphold the level of care we've always promised and to ensure a safe and clean environment.

Patient Registration

To help us shorten your waiting period, we ask that all patients scheduled with a first time appointment, complete our Patient Registration form online by visiting us at www.ClinicOMS.com. Alternatively, you may print our Patient Registration form (provided for you in this Digital Patient Care Package) in advance and complete it prior to arriving for your appointment.

Walk-Ins

Please refrain from vising our clinic without an appointment. During these times we ask that you call the office for an appointment so that we may take proper steps to pre-screen everyone appropriately. If you have any questions regarding your appointment, whether it's administrative or treatment related, we can help over the phone.

Screening

You will receive a call from our office prior to your appointment date to pre-screen for symptoms of COVID-19. You will be re-screened on the day of your appointment to ensure everyone's safety. A copy of the screening questionnaire has been provided for you in this Digital Patient Care Package.

Temperature

As part of our pre-screening measure, all patients entering the clinic for an appointment will have their temperature taken at arrival. If you should experience a fever within 14 days of visiting our clinic, please inform our office immediately.

Accompanying Guests

During this time, only patients will be allowed in the patient room. To ensure safety and to enable us to serve more patients, we will ask that all accompanied visitors remain outside the clinic. At the discretion of the doctors, accommodations will be made for any patient who requires the assistance of *one* family member or caretaker.

PPE (Personal Protective Equipment)
To ensure the safety of our patients and the safety of our team, everyone in our clinic is required to wear a mask. Although you can't see our faces, know that we're sporting all sorts of smiles. We're excited to be back and we're happy to be here for you once again.

Checking-in
The day of your appointment, we ask that you remain in your vehicle and phone our office when you arrive for your appointment time. Our patient care coordinators will meet you at your vehicle and provide you with all the necessary forms that you need to complete. When the clinical team is ready for you, they will call you in. When you first enter the clinic, please put on your mask and sanitize your hands.

Reception Area/Waiting Room
We have made every effort to reduce your waiting time. However, if there is a need for you to wait in the waiting room, we have reduced the number of chairs and provided appropriate distancing for your comfort and safety.

Covid-19 Acknowledgement
To receive care in our clinic, you will be asked to sign an acknowledgement form that provides you with information regarding associated risks during the pandemic. A copy has been provided for you in this Digital Patient Care Package and we ask that you take this opportunity to review it in advance.

PATIENT RESPONSIBILITY

We understand that this is a difficult time for our community. Our safety and good health should remain of utmost importance during this pandemic. However, we can't do it alone. We have gone above the ministry standards in trying to provide a safe environment for us all, and we ask that you do your part. Be honest. Be patient. If you feel you may be experiencing symptoms of Covid-19 or suspect you have been exposed to the virus, please inform our team as soon as possible and self-isolate. If you are visiting the clinic with an appointment, please be aware that although some of our protocols have changed, we are doing our very best to continue to care for every single patient in a timely manner. Unforeseen circumstances may arise and we ask that you kindly be patient if you find yourself waiting longer than expected.

Feedback
We want to hear from you! If you feel we've done something right, let us know. If you feel we can improve on something, take a moment and make us aware of it. #We're in this together.

Acknowledgement of New Office Protocol

I understand that ClinicOMS has put in place some new measures to help ensure the safety and well-being of its patients, team, families and community. As such, I am aware that:

- I must wear a mask covering my nose and mouth when inside the clinic.
- I must use hand sanitizer when entering and leaving the clinic.
- I will remain in my vehicle when I arrive for my appointment and phone the clinic to check-in. I will NOT enter the clinic without having been instructed to do so by ClinicOMS.
- I will be asked a series of pre-screening questions, in addition to having my temperature taken, prior to seeing the surgeon.
- Unless I am a minor, or need translation/assistance due to language/physical/mental limitation(s), I am strongly encouraged to attend my appointment without accompaniment.

If you have any questions regarding the above measures, please notify our patient care coordinators prior to your appointment date.

Patient Acknowledgement: Covid-19 Pandemic Emergency Dental Risk

Please read the patient acknowledgement below, and initial or sign in all areas indicated.

I understand the novel coronavirus causes the disease known as COVID-19 and that it is currently a pandemic. I understand that the novel coronavirus virus has a long incubation period during which carriers of the virus *may not show symptoms and still be contagious.* For this reason, I understand that the federal and provincial authorities have recommended that Ontarians stay home and avoid close contact with other people when at all possible. __________ (initial)

I understand the federal and provincial authorities have asked individuals to maintain social distancing of a least two (2) meters (six (6) feet) and I recognize it is not possible to maintain this distance while receiving dental treatment. __________ (initial)

I understand that oral surgery/dental procedures can create water and/or blood spray, which is one way that the novel coronavirus can spread. I understand that the ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the novel coronavirus. __________ (initial)

I understand that due to the visits of other patients, the characteristics of the novel coronavirus, and the characteristics of dental procedures, that I have an elevated risk of contracting the novel coronavirus simply by being in the dental office. __________ (initial)

I confirm that I do NOT have any TWO OR MORE or the following symptoms of COVID-19: (i) fever, (ii) new or worsening cough, (iii) sore throat, (iv) runny nose or (v) headache. __________ (initial)

If I received COVID-19 test results in the past three (3) months, the last results I received were negative. __________ (initial) If applicable, approximate date of test: ________________________ (initial)

I confirm that I am currently not waiting for the results of a test for COVID-19. __________ (initial)

I confirm that this is not currently a period during which public health authorities required I self-isolate. __________ (initial)

I verify the information I have provided on this form is truthful and complete. I knowingly and willingly consent to have surgical/dental treatment completed during the COVID-19 pandemic.

Patient Signature: ______________________ Print Name: ______________________ Date: ______________
(If 16 years of age or older)

Parent/Guardian Signature: ______________________ Print Name: ______________________ Date: ______________
(If patient is under the age of 18)

Patient Screening Form

Staff Screener: Date:

Patient Name: Patient Age: Patient Temperature:

Screening Questions

Question	Answer
Have you had close contact with anyone with acute respiratory illness or travelled outside of Ontario in the past 14 days?	YES NO
Do you have a confirmed case of COVID-19 or had close contact with a confirmed case of COVID-19?	YES NO
Do you have any of the following symptoms: * Fever * New onset of cough / Worsening chronic cough * Shortness of breath * Difficulty breathing / Difficulty swallowing * Sore throat * Decrease or loss of sense of taste or smell * Chills * Headaches * Unexplained fatigue/malaise/muscle aches (myalgias) * Nausea/vomiting, diarrhea, abdominal pain * Pink eye (conjunctivitis) * Runny nose/nasal congestion without other known cause	YES NO
Are you 70 years of age or older, experiencing any of the following symptoms: delirium, unexplained or increased number of falls, acute functional decline, or worsening of chronic conditions?	YES NO

Patient Information

Mr.❍ Mrs.❍ Ms.❍ Dr.❍

Male ❍ Female ❍ X ❍

First Name: ______________________
Last Name: ______________________
Birth Date: ______________ Age ______
Street Address: ______________________
Suite/Unit: ______________________
City / Postal Code: ______________________
Patient Occupation: ______________________
Patient Health Card: ______________________
Patient Email: ______________________

Patient Cell #: ______________________
Patient Home #: ______________________
Patient Business #: ______________ Ext ______
Current Dentist: ______________________
Orthodontist: ______________________
Family Physician: ______________________
Family Physician #: ______________________
Medical Specialist: ______________________
Medical Specialist #: ______________________
Pharmacy #: ______________________

Have you been referred by someone other than your dentist? If yes, who may we thank? ______________________
Has a family member ever been a patient of our practice? ______________________
What is the reason for your visit? ______________________

Insurance Information

Primary Insurance Co: ______________________
Group/Policy #: ______________________
Certificate ID #: ______________________
Subscriber's Name: ______________________
Subscriber's Birth Date: ______________________
Relationship to Patient: ______________________

Secondary Insurance Co: ______________________
Group/Policy #: ______________________
Certificate ID #: ______________________
Subscriber's Name: ______________________
Subscriber's Birth Date: ______________________
Relationship to Patient: ______________________

❍ I do not have dental insurance.

Who will be legally and financially responsible for your account? (if someone other than the patient)

First Name: ______________________
Last Name: ______________________
Birth Date: ______________________
Full Address: ______________________
City / Postal Code: ______________________

Cell #: ______________________
Home #: ______________________
Business #: ______________ Ext ______
Email: ______________________
Relationship to patient: ______________________

Emergency Contact

Full Name: ______________________
Relationship to Patient: ______________________

Cell #: ______________________
Other #: ______________________

Medical History Questionnaire

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by doctor-patient confidentiality. The dentist will review the questions and explain any that you do not understand. Please complete the *entire* form.

		Yes	No
1	Are you being treated for any medical condition at the present or within the past year? *If yes, please explain.*	❍	❍
2	When was your last medical checkup?		
3	Has there been any change in your general health in the past year? *If yes, please explain*.	❍	❍
4	Are you taking any medications, non-prescription drugs or herbal supplements of any kind? *If yes, please list.*	❍	❍
5	Do you have any allergies? *If yes, please list using the categories below*. a) Medications: b) Latex/Rubber products: c) Other (i.e. hay fever, foods, shellfish):	❍	❍
6	Have you ever had a peculiar or adverse reaction to any medicines or injections? *If yes, please explain.*	❍	❍
7	Do you have or have you ever had asthma? *If yes, please explain.*	❍	❍
8	Do you have or have you ever had any heart or blood pressure problems?	❍	❍
9	Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant? *If yes, please explain.*	❍	❍
10	Do you have a prosthetic or artificial joint? *If yes, please note the date of surgery.*	❍	❍
11	Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)?	❍	❍
12	Have you ever been hospitalized for any illnesses or operations? *If yes, please explain.*	❍	❍

13 Have you ever taken or currently take any of the following medications?

	Yes	No		Yes	No		Yes	No
Coumadin (warfarin)	❍	❍	Xarelto (rivaroxaban)	❍	❍	Fosamax (alendronate)	❍	❍
Aspirin (ASA)	❍	❍	Eliquis (apixaban)	❍	❍	Actonel (risedronate)	❍	❍
Plavix (clopidogrel)	❍	❍	Pradaxa (dabigatron)	❍	❍	Prolia (denosumab) injection	❍	❍

14 Have you ever had or currently have…

	Yes	No
Chest pain, angina	❍	❍
Heart attack / Stroke / TIA	❍	❍
Shortness of breath	❍	❍
Fainting spells	❍	❍
Migraine/Headaches	❍	❍
Rheumatic fever	❍	❍
Mitral valve prolapse	❍	❍
Heart murmur	❍	❍
Pacemaker	❍	❍
Lung disease	❍	❍
Tuberculosis	❍	❍
Cancer	❍	❍
Steroid therapy	❍	❍
Diabetes	❍	❍
Stomach ulcers	❍	❍
Arthritis	❍	❍
Bipolar/Schizophrenia/Psychiatric disorder	❍	❍

	Yes	No
Seizures (epilepsy)	❍	❍
Glaucoma	❍	❍
Kidney disease	❍	❍
Lupus	❍	❍
Neck Injury	❍	❍
Thyroid disease	❍	❍
Anemia	❍	❍
Sickle cell disease	❍	❍
Hemophilia	❍	❍
Bleeding problem/disorder	❍	❍
Drug/alcohol/cannabis use or dependency	❍	❍
Nervous disorder	❍	❍
Osteoporosis	❍	❍
Hepatitis, jaundice or liver disease	❍	❍
Blood transfusion	❍	❍
TMJ (jaw) problems	❍	❍
Dementia/Alzheimer’s	❍	❍

		Yes	No
15	Are there any conditions or diseases not listed above that you have had or currently have? *If yes, please list.*	❍	❍
16	Are there any diseases or medical problems that run in your family (e.g. diabetes, cancer or heart disease)? *If yes, please list.*	❍	❍
17	Have you or anyone in your family ever have an unusual or serious reaction to general anesthesia (i.e. malignant hyperthermia)?	❍	❍
18	Do you smoke or chew tobacco products? *If so, how often?*	❍	❍
19	Are you nervous during dental treatment?	❍	❍
20	Do you have anything removable in your mouth (i.e. denture, piercing)?	❍	❍
21	Are you a gagger (i.e. when x-rays are being taken)?	❍	❍
22	Are you breastfeeding or pregnant? *If pregnant, what is the expected delivery date?*	❍	❍
23	Is there anything you would like to speak to the doctor about privately?	❍	❍
24	What is your height?		
25	What is your weight?		

Consent to Medical History and Consultation

I hereby state that the above information is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medication(s) change, I will inform the doctor without fail. I will not hold my surgeon, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I grant permission for my physician, dentist and other healthcare providers involved in my treatment to be contacted by Dr. Donald Hui/Associate(s) and staff for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

Patient Signature: ______________________ Print Name: ______________________ Date: ______________
(If 16 years of age or older)

Parent/Guardian Signature: ______________________ Print Name: ______________________ Date: ______________
(If patient is under the age of 18)

Dentist Signature: ____ Date: ______________

Consent to Financial Policy

I hereby recognize that my visits to this office are NOT covered by OHIP. I am aware that **this office does not take payment from my insurance company**. Please Initial __________

This is a non-assignment office, and **I am expected to pay in full for all services rendered on the day of my appointment**. If accurate information is provided, the office patient coordinators will gladly assist in submitting my dental claims to the appropriate insurance company on my behalf. Furthermore, I acknowledge that payment at this office is accepted in the form of Visa, MC, Amex, Debit and/or Cash. Regretfully, no cheques**.** I understand and agree to this policy.

Patient Signature: ______________________ Print Name: ______________________ Date: ______________
(If 18 years of age or older)

Parent/Guardian Signature: ______________________ Print Name: ______________________ Date: ______________
(If parent/guardian will be making payment on behalf of patient)

Consent to the Collection, Uses and Disclosures of Patients' Personal Health Information

I hereby acknowledge that a copy of this office's policy for Collection, Uses and Disclosures of Patient's Personal Health Information has been made readily accessible to me. I have reviewed the information that explains how this office will use my personal health information, and the steps this office is taking to protect my information. I have been given the opportunity to ask any questions I may have. My signature below signifies that Dr. Donald Hui/Associate(s) and staff can collect, use and disclose my personal health information as set out in the information about the office's privacy policies.

Patient Signature: ______________________ Print Name: ______________________ Date: ______________
(If 16 years of age or older)

Parent/Guardian Signature: ______________________ Print Name: ______________________ Date: ______________
(If patient is under the age of 18)

Office Signature: ____ Date: ______________

Dr. Donald Hui Dentistry Professional Corporation Privacy Policy
Collection, Uses and Disclosures of Patients' 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. Donald Hui acts as the Privacy Information Officer

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.

Below, 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 any member of our office staff. We are all committed to ensuring that you receive the best quality dental care.

How Our Office Collects, Uses and Discloses Patients' Personal 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 your 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 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 and physicians
- 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 a 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

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 *Regulatory Health Professions Act* (RHPA) for the purposes of the Royal College of Dental Surgeons of Ontario fulfilling its mandate under the RHPA.