VIVID Prosthodontics

Dr. Arif Sumar B.Sc., D.M.D., F.R.C.D. (c)

WWW.VIVIDDENTAL.CA
Tel: 780.421.4441
301, 6074 ANDREWS WAY SW
EDMONTON, AB T6W 3S9

MISSION STATEMENT

VIVID Prosthodontics' mission is to provide the utmost quality of care in a safe, relaxing and professional environment. We hold ourselves to the highest standards of excellence when treating our patients. Our professional and personable staff will be happy to answer any questions or concerns that you may have regarding treatments, procedures, dental emergencies, or about any of the state-of-the-art technology we utilize in our office. We ensure strict compliance with all regulatory and ethical guidelines set forth by the Alberta Dental Association. It is our sincere pledge that we will do our best to earn your confidence by always putting your needs and interests first.

PATIENT PRIVACY CONSENT FORM

We understand the importance of protecting your personal information and are committed to collecting, using and disclosing this information responsibly. All staff members who come in contact with your personal information are aware of its sensitive nature. We comply by the Health Information Act Legislation.

In this consent form, we have outlined the personal information required 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 protocols
- Our privacy protocols comply with privacy legislation, standards of our regulatory body as well as the law.

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

This office will collect, use and disclose information about you for the following reasons;

- To deliver safe and efficient patient care
- To assess your health and needs
- To advise you of recommended treatment options
- To communicate with your other health care providers, including specialists and referring dentists
- To allow us to maintain communication and contact with you in order to distribute health care information and to book and confirm your appointments.
- To allow us to efficiently follow up with treatment care, invoice for goods and services, as well as collect funds for past and present treatment.
- For teaching and demonstrating purposes on an anonymous basis.
- To complete and submit claims for third party adjudication and payment.
- To comply with legal and regulatory requirements including the delivery of patients' charts and records to governing bodies 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 governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes.
- To permit potential purchasers, practice brokers or advisers to evaluate the practice or conduct an audit in preparation for a practice sale.
- To deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages if any.
- To prepare materials for the Health Profession and Appeal Review Board.
- To comply with the law.

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

Our office will not under any condition, supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly for you to review and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We will also advise you if such a release is appropriate.

The patient/ doctor relationship requires mutual respect and trust. As such, our office has a zero-tolerance policy for any abusive or threatening behaviors including but not limited to: The use of profanity, display of anger or intimidation both verbally and physically towards the staff and/or doctors. I acknowledge and agree to the above prerequisites in order to be a patient at VIVID Prosthodontics. I agree to abide by these guidelines and understand that failure to do so can result in immediate dismissal from the office.

PATIENT CONSENT

I have reviewed the above information that explained 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. Arif Sumar can collect, use and disclose personal information as set out above in the information about the office's privacy policies. I authorize the taking of oral photographs during diagnosis, treatment and subsequent recare appointments. The photographs will be used in the most dignified manner for the purpose of patient and dental education in presentations, lectures, and scientific papers.

X _____

Patient Signature

X _____

Witness Signature

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PATIENT INFORMATION

DATE _____

PATIENT NAME: _____
LAST **FIRST** **(PREFERRED)**

DATE OF BIRTH _____ /_____/_____ ☐ **MALE** ☐ **FEMALE**
DAY **MONTH** **YEAR**

ALBERTA HEALTH CARE NO. _____

☐ **CHILD** ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **OTHER**

If under 18 years of age, please provide parent/guardian name(s):

ADDRESS _____

_____ _____ _____
CITY **PROVINCE** **POSTAL CODE**

HOME: _____ **CELL:**_____ **BUSINESS:** _____

OCCUPATION _____

EMAIL _____

(your email will be used to correspond regarding your appointments)

HOW DID YOU HEAR ABOUT US?

☐ **REFERRAL** ☐ **INTERNET** ☐ **FRIEND/FAMILY** ☐ **ADVERTISEMENT** ☐ **OTHER** _____

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, PLEASE PROVIDE INFORMATION.

_____

NAME RELATIONSHIP PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

SUBSCRIBER NAME:_____ SUBSCRIBER'S DOB:_____

GROUP/POLICY #:_____ ID #:_____

SECONDARY INSURANCE CARRIER: _____

SUBSCRIBER NAME:_____ SUBSCRIBER'S DOB:_____

GROUP/POLICY #:_____ ID #:_____

WE REQUIRE YOUR DENTAL INSURANCE INFORMATION FOR PRE-DETERMINATIONS ONLY. YOU ARE DIRECTLY RESPONSIBLE FOR ALL CHARGES INCURRED IN THIS OFFICE. WE DO NOT DIRECT BILL.

IS THIS A MEDICAL/LEGAL CASE? _____ **IF SO, PLEASE GIVE THE FOLLOWING INFORMATION:**

LAWYER'S NAME _____ PH. NUMBER _____

DENTAL HISTORY

GENERAL DENTIST INFORMATION

Do you regularly see a dentist for routine exams/treatment and teeth cleanings? ☐ **YES** ☐ **NO**

DENTIST NAME: _____ CLINIC: _____

PH. NUMBER: _____

ADDRESS: _____

Reason for Referral: _____

Date of last dental visit: _____ **Treatment Type**_____

☐ **Y** ☐ **N** Are you currently having dental discomfort? If yes, explain _____

_____

☐ **Y** ☐ **N** Have you had any unpleasant dental experiences? If yes, please explain_____

_____

☐ **Y** ☐ **N** Have you had any injuries to your mouth/teeth/head? If yes, explain _____

_____

☐ **Y** ☐ **N** Does it hurt to bite or chew?

☐ **Y** ☐ **N** Are you missing any teeth?

☐ **Y** ☐ **N** Have you ever had any problems with dental freezing (local anesthetic)?

☐ **Y** ☐ **N** Do you have jaw pain or clicking in the jaw joints?
If yes, is it on the right or left side, or both?_____

☐ **Y** ☐ **N** Have you had any treatment for your TMJ (joint) pain?

☐ **Y** ☐ **N** Do you snore at night or wake up feeling unrested?

☐ **Y** ☐ **N** Do you clench or grind your teeth?

☐ **Y** ☐ **N** Do you wear a night guard or splint?

☐ **Y** ☐ **N** Do you brush your teeth regularly?

☐ **Y** ☐ **N** Do you floss your teeth regularly?

☐ **Y** ☐ **N** Are you happy with the aesthetics of your teeth?

☐ **Y** ☐ **N** Have you had Botox treatment in the past or are you interested in this service?

☐ **Y** ☐ **N** Have you had dermal filler treatment in the past or are you interested in this service?

MEDICAL HISTORY

PRIMARY PHYSICIAN INFORMATION

PHYSICIAN NAME: _____ CLINIC: _____

PH. NUMBER: _____

PHARMACY NAME & PHONE NUMBER: _____

☐ **Y** ☐ **N** Are you under a physician's care now?

☐ **Y** ☐ **N** Have you been hospitalized in the past 5 years? If yes, please explain_____

_____

☐ **Y** ☐ **N** Do you have any serious illnesses/surgeries?_____

_____

☐ **Y** ☐ **N** Have you ever had any abnormal bleeding? _____

☐ **Y** ☐ **N** Do you use tobacco in any form? If yes, type & amount per day: _____

☐ **Y** ☐ **N** Do you use recreational drugs? If yes, type & amount per day: _____

☐ **Y** ☐ **N** Is **pre-medication** required before dental visits due to heart conditions or artificial joints?

☐ **Y** ☐ **N** Are you taking any prescription or non-prescription medications/drugs?

Please list ALL medications you are currently taking. If you have a list of your medications, our receptionist would be more than happy to photocopy it for you.

Drug Name	Dosage	Reason Prescribed

DO YOU HAVE ANY ALLERGIES OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? ☐ NONE

☐ Penicillin Antibiotics ☐ Local Anesthetic (Freezing) ☐ Latex ☐ Metal Sensitivity ☐ Codeine

☐ Aspirin ☐ Nitrous Oxide Sedation ☐ Sulfa Drugs

Please list any other allergies: _____

DO YOU HAVE, OR HAVE YOU EVER HAS ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐Heart Attack
☐Heart Trouble
☐Heart Murmur
☐Pacemaker
☐High Blood Pressure
☐Low Blood Pressure
☐Asthma
☐Respiratory Disease
☐Tuberculosis
☐Rheumatic Fever
☐Arthritis/Rheumatism
☐ Blood Disorder
☐ Acid Reflux
☐ Sinus Problems
☐Dry Mouth

☐Autoimmune Disorder
☐AIDS/HIV
☐Hepatitis A, B, C
☐Anorexia/Bulimia
☐Jaundice
☐Osteoporosis
☐ Stroke
☐Dizziness/Fainting
☐Frequent Headaches
☐Anxiety
☐Psychiatric Treatment
☐Depression
☐Neurological Disorder
☐Epilepsy/Seizures
☐Cold Sores

☐Iron Deficiency (Anemia)
☐Kidney Disease
☐Liver Problems
☐Thyroid Condition
☐Stomach Problems
☐Diabetes
Type I/II _____
☐Artificial Joints
Hip/Joint Replacement: _____
Date of surgery: _____
Explain
☐Cancer
Explain _____
☐Radiation/Chemotherapy Treatment
Explain _____

Females:
☐Currently Pregnant (Month:_____)
☐Currently breast feeding

Are there any other medical concerns that were not listed? If so please explain: _____

_____

The information above is correct to the best of my knowledge. I authorize Dr. Arif Sumar and his staff to provide dental treatment to me. The taking intra oral photographs during diagnosis, treatment, and subsequent recare appointments. If it is necessary to be treated by another practitioner, I authorize that my records in whole or part may be transferred to that practitioner.

X_____

Patient Signature

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CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Dr. Arif Sumar and his staff to take radiographs of my dentition and/or photographs of the head and neck areas, including the profile, face, teeth, smile, and intraoral features, pre-, during, and post-treatment for the purposes of:

- Internal office use,
- Treatment planning,
- Education,
- Publication in professional journals,
- Advertising

I understand that my identity will be blurred and that my personal information will be protected.

I do not expect compensation, financial or otherwise, for the use of these photographs.

I hereby warrant that I am of legal age and have the right to contract my own name, or I am not of legal age and my parent/ legal guardian whose signature is witnessed below is executing this release. I/my guardian has read the above consent prior to its execution, and I/my guardian am/is fully familiar with the agreement.

X _____

Patient Signature

Date: _____

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CANCELLATION POLICY

Our goal at VIVID Prosthodontics is to provide quality prosthetic dental care to our patients in a timely manner. In order to ensure an adequate amount of time is allotted to each patient, it is important to be on time for your appointments. Attending appointments late or missing appointments altogether affects other patients who are scheduled for that day or who would like to be scheduled sooner.

VIVID Prosthodontics requires a minimum of 48 hours' notice to cancel appointments. Notice of less than 48 hours will result in a cancellation fee. The fee will depend on the type of appointment cancelled and the amount of time scheduled for the procedure.

Please take a few minutes to review our no-show/ cancellation policy and sign at the bottom of the form.

- Call the clinic at (780) 421-4441 to cancel or reschedule. The phones are on between 8:00 a.m. to 3:00 p.m. Monday through Friday. The office is closed on the weekend and all statutory holidays.
- Cancellation of any appointments must be done with one of our staff members. We are unable to accept such requests via voice-mail or email.
- If you book your appointment within the 48-hour time frame, the policy is in effect immediately.
- If you arrive later than halfway through a scheduled appointment this will constitute a "Missed Appointment".
- Patient that are late for their appointments may be required to re-schedule for a later time or another day and appropriate charges for the late or missed appointment will apply.
- All incurred fees must be cleared before your visit with the doctor.

Depending on the type of your appointment you will be charged a fee for appointments missed, canceled or re-scheduled with less than 48 business hours' notice. See fee schedule below:

Initial Consultation (1.5 hours)	$ 185.00
Minor Prosthodontic Treatment (Less than 2 hours)	$ 250.00
Major Prosthodontic Treatment (More than 2 Hours)	$ 500.00 +
Follow-up Appointments (1 hour)	$ 50.00
Dental Hygiene Appointment	$100.00

I, _____(Patient), have read the above information that explains the missed appointment, late cancellation and re-scheduling fee policy. I understand that at least 48 business hours' notice is required to avoid these charges.

X _____

Patient Signature

Date: _____