VIVID Prosthodontics

DR. KEITH COMPTON B.Sc. D.D.S. F. Pros. M.Sc. F.A.I.D. F.I.C.D
DR. ARIF SUMAR B.Sc. D.M.D. F.R.C.D(c)

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 it's 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.

Your information may be assessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

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.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision and the process involved.

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. Keith Compton/ 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's Signature

Date: _____...

X _____

Witness Signature

Date: _____...

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PATIENT INFORMATION

DATE _____

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

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

☐ **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** **PH. 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 _____

PLEASE TURN OVER NEXT PAGE -->

DENTAL HISTORY

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?

GENERAL DENTIST INFORMATION

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

DENTIST _____ **CLINIC** _____

PH. NUMBER _____

ADDRESS _____

_____

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

MEDICAL HISTORY

PRIMARY PHYSICIAN INFORMATION

PHYSICIAN _____ **CLINIC** _____

PH. NUMBER _____

ADDRESS _____

_____

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

PLEASE TURN OVER NEXT PAGE -->

☐ **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, 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 Reflex
☐ 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

PLEASE TURN OVER NEXT PAGE -->

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_____
_____
_____

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. Keith Compton/Dr. Arif Sumar and his staff to provide dental treatment to me. The taking intra oral photographs during diagnosis, treatment, and subsequent recare appointments. The photographs and data collected from treatment rendered may be used in scientific papers and presentations for teaching purposes. 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.

Patient's Name _____

Signature_____ **Date**_____