

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



Prosthodontics

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

WWW.VIVIDDENTAL.CA

Tel:

780.421.4441

450, 10665 JASPER AVENUE

EDMONTON, AB T5J 3S9

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: _____

ADDRESS: _____

- 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

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Iron Deficiency (Anemia) |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | Type I/II _____ |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Frequent Headaches | Hip/Joint Replacement: _____ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anxiety | Date of surgery: _____ |
| <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Psychiatric Treatment | Explain _____ |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Acid Reflex | <input type="checkbox"/> Neurological Disorder | Explain _____ |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Radiation/Chemotherapy Treatment |
| <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Cold Sores | 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.

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.

X

Patient Signature

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.

Date: _____

Patient's Name (printed): _____

Patient's Signature: _____

Provider's Name: _____

Provider's Signature: _____