VicDen Centre

Implant, Cosmetic & General Dentistry

Welcome to Our Office

NAME _____ ☐ **M**

FIRST MIDDLE LAST ☐ **F**

PREFERRED NAME _____ Marital Status: ☐ Single ☐ Married ☐ Other

Address _____

City _____ Province _____ Postal Code _____

Phone: CELL _____ HOME _____ BUSINESS _____

EMAIL _____

Date of Birth _____ / _____ / _____

Day Month Year

Person responsible for this account:

☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other _____

Name_____ Signature_____

How did you hear of our clinic? ☐ Referral, If so, whom can we thank? _____

☐ Website ☐ Sign ☐ Other _____

DENTAL BENEFIT PLAN ☐ **YES** ☐ **NO** **Please provide a copy of your card!**	
PRIMARY DENTAL BENEFIT PLAN INFORMATION	**SECONDARY DENTAL BENEFIT PLAN INFORMATION**
Plan holder's Name:	Plan holder's Name:
Plan holder's Date of Birth:	Plan holder's Date of Birth:
Benefit Company:	Benefit Company:
Group/Policy #	Group/Policy #
ID #	ID #
Are you familiar with your plan details? ☐ Yes ☐ No	Are you familiar with your plan details? ☐ Yes ☐ No
Employer:	Employer:

In case of Emergency notify _____

Relationship _____ Phone _____

All information will be kept strictly confidentrial in accordance with the privacy act.

PLEASE SEE NEXT PAGE **INITIAL** _____

HAVE YOU EVER HAD, OR BEEN DIAGNOSED WITH, ANY OF THE FOLLOWING?

Please Check YES or NO for each item below:

Heart Condition ☐ **YES** ☐ **NO**
Explain _____
Heart Murmur ☐ **YES** ☐ **NO**
Bypass Surgery/Stent ☐ **YES** ☐ **NO**
Heart Valve Replacement ☐ **YES** ☐ **NO**
Pacemaker ☐ **YES** ☐ **NO**
Rheumatic fever ☐ **YES** ☐ **NO**
Stroke ☐ **YES** ☐ **NO**
High Blood Pressure ☐ **YES** ☐ **NO**
Low Blood Pressure ☐ **YES** ☐ **NO**
Chest pains/Angina ☐ **YES** ☐ **NO**
Joint Replacement ☐ **YES** ☐ **NO**
Date: _____ Joint: _____
Blood Disorders ☐ **YES** ☐ **NO**
Excessive Bleeding ☐ **YES** ☐ **NO**
Cancer ☐ **YES** ☐ **NO**
Explain _____
_____
Radiation Therapy ☐ **YES** ☐ **NO**
Chemotherapy ☐ **YES** ☐ **NO**
Congenital or
Genetic Disorders ☐ **YES** ☐ **NO**
Hepatitis ☐ **YES** ☐ **NO**
AIDS/HIV ☐ **YES** ☐ **NO**
Tuberculosis ☐ **YES** ☐ **NO**
Diabetes ☐ **YES** ☐ **NO**
Epilepsy/Seizures ☐ **YES** ☐ **NO**
Kidney Disease ☐ **YES** ☐ **NO**
Liver Disease ☐ **YES** ☐ **NO**
Ulcers/Stomach Trouble ☐ **YES** ☐ **NO**
Surgery ☐ **YES** ☐ **NO**
Explain:_____
Arthritis ☐ **YES** ☐ **NO**
Asthma ☐ **YES** ☐ **NO**
Drug Reaction ☐ **YES** ☐ **NO**
Explain _____
Recreational Drug Use ☐ **YES** ☐ **NO**
Depression ☐ **YES** ☐ **NO**
Mental/Nervous Disorder ☐ **YES** ☐ **NO**

Tobacco Products ☐ **YES** ☐ **NO**
Frequent Urination ☐ **YES** ☐ **NO**
Unusual Weight Change ☐ **YES** ☐ **NO**
Frequent Headaches ☐ **YES** ☐ **NO**
Bleeding Gums ☐ **YES** ☐ **NO**
Receeding Gums ☐ **YES** ☐ **NO**
Grinding/Clenching ☐ **YES** ☐ **NO**
Loose Teeth ☐ **YES** ☐ **NO**
TMJ/Jaw Problems ☐ **YES** ☐ **NO**
Shifting Teeth ☐ **YES** ☐ **NO**
Braces ☐ **YES** ☐ **NO**
Allergies/Adverse Reactions ☐ **YES** ☐ **NO**
Type: _____
_____
_____
_____

Have you ever taken **antibiotic pre-medication** for dental treatment? ☐ **YES** ☐ **NO**

Are you taking any medications? (prescriptions/non-prescriptions, supplements, vitamins)? ☐ **YES** ☐ **NO**

If so, what? (name, dose, frequency)
_____
_____
_____
_____
_____

If there is a medical condition not listed and applies to you, please list below:
_____
_____
_____
_____

Are you presently under the care of a physician
☐ **YES** ☐ **NO** If so, why?
_____
_____
_____

Females: Are you now:
Pregnant ☐ **YES** ☐ **NO**
Taking birth control ☐ **YES** ☐ **NO**
Breast feeding ☐ **YES** ☐ **NO**

PLEASE SEE NEXT PAGE **INITIAL** _____

MAIN REASON FOR TODAY'S VISIT:_____

_____

_____

_____

_____

_____

HEALTH HISTORY

Previous dentist's name _____ Date of last dental visit _____

Family physician's name_____ Date of last medical visit _____

Address _____ Phone _____

RESPONSIBILTY & CONSENT FOR DENTAL TREATMENT

I hereby authorize and request the performance of dental services. I also give my consent to any advisable and necessary dental procedure, medications or anesthetics to be administered by Dr. Denysenko or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs and X-rays, which may be used in the teaching of dentistry and used in dental publications. I understand and acknowledge that I am financially responsible for the services provided regardless of insurance coverage. I have read and agree with the office policy below. I also understand that the treatment estimate presented is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment and its fee. I believe the information given in the pages of this medical and dental history to be true to the best of my knowledge.

PATIENT SIGNATURE or GUARDIAN_____ **DATE**_____

VICDEN CENTRE OFFICE POLICY

Our office policy states that services rendered in this office are the financial responsibility of the patient. VicDen Centre is based on a non-assignment process with your dental insurance company. Our team is more than happy to help process your dental claims for you to receive reimbursement. Payment is to be made in full at the end of each appointment.

Dental insurance is intended to cover a portion, but not the entire cost of your dental care. We will help you with treatment plans and pre-determinations to the best of our ability.

We care about our patients and want to provide the best service and dental care. Our primary focus is your dental treatment and not the paperwork. In doing so, we will give you our full attention and the best possible treatment during your visit.

You will be reminded of your appointment well ahead of your scheduled appointment date. This time is reserved specifically for you. **If you are unable to keep your appointment we require 48 hours' notice, otherwise you will be charged $200.00 for the lost time**.

PATIENT SIGNATURE or GUARDIAN_____ **DATE**_____

PLEASE SEE NEXT PAGE **INITIAL** _____

PRIVACY INFORMATION POLICY

In compliance with the Federal Personal Information Protection Electronic Documents Act (PIPEDA). Alberta's Personal Information Protection Act (PIPA) and the Health Information Act (HIA) VicDen Centre has created the following policy to ensure the privacy of our patients and staff are protected.

Privacy of your personal information is an essential part of providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. We also strive to be as open as possible with you about the way we handle your information.

The personal information we collect from you is necessary to provide you with appropriate care. This includes contact information, medical information and financial information. Once information is collected we ensure it remains secure. We do not share your personal information outside our office for marketing, promotional, publicity, educational or research purposes without your specific consent.

PERSONAL INFORMATION AND PRIVACY CONSENT FORM

By signing this form, I agree that VicDen Centre can collect and disseminate my personal information on an ongoing basis (including contact information, financial information, and relevant medical information) as required for the following purposes:

- To open and update patient files
- To provide appropriate dental treatment
- To process claims for reimbursement from health benefit providers and insurance companies
- To contact Patients regarding the need for further examination, treatment or information
- To provide other Dentists or Dental Specialists relevant information needed for a second opinion or referral
- To provide other health care professionals (such as physicians) relevant information
- To allow for transfer of x-rays between professional offices (Dentists, Dental Specialists)

I understand that VicDen Centre only collects my personal information in order to provide me with appropriate care.

PATIENT NAME_____ **DATE**_____

PATIENT SIGNATURE or GUARDIAN _____

Please keep me informed with VicDen Centre updates via □ E-mail

I wish to receive appointment confirmations via □ E-MAIL □ TEXT MESSAGE

INITIAL _____

PATIENT NAME_____

MEDICAL HISTORY UPDATED

Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____
Date:_____Initials:_____ Date:_____Initials:_____

Doctor's Notes and Updates_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE INITIAL THIS PAGE! **INITIAL** _____