Personal Information Protection Act Consent Form

Lloydminster Denture Clinic Inc.

In our office, we are dedicated to ensuring the protection of our patients' personal information and insuring that this information is used only in a professional manner. The following indicates some of the information that is collected, why we collect it, and when we may disclose your personal information. We collect, use and disclose your personal information where permitted or required by law.

Contact Information

We collect contact information from our patients such as full name, home address, home telephone number(s), home email address, work address, work telephone number(s), work email address, and cellular phone number. This information is considered as Contact Information and it is collected for a variety of purposes including the following:

- To open and update a patient file;
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts;
- To process claims for payment or reimbursement from a third-party health benefit provider or insurance company*;
- To send correspondence to our patients regarding need for further examination or treatments; and
- To send correspondence to our patients regarding our clinic and practice.* Contact information is/may be disclosed to a third party health benefit provider or insurance company when submitting a claim on the patients' behalf, for payment or reimbursement of all or part of the cost of the treatment provided, or when a patient has requested a preauthorization of a proposed treatment.

Medical/Dental History

We collect from our patients, information about their health history, family health history, physical and mental condition, their dental health history, and family dental health history. This Medical/Dental information is collected for a variety of purposes and may be used in part to assist us in diagnosing dental conditions and providing appropriate treatment for you, and may be disclosed for the following purposes:

- To a third-party health benefit provider or insurance company, in the submission of a claim on behalf of the patient, for reimbursement or payment of all or part of the cost of the treatment ;
- To a third-party health benefit provider or insurance company on behalf of the patient, in the submission of a preauthorization of treatment;
- To other health/dental providers where, upon your consent, we are seeking a second opinion;
- To other health/dental providers where, upon your consent, we have referred you to for additional\alternative treatment;

Financial Information

We collect information related to financial matters for facilitation of payment of your treatment(s).

Future Use

If consideration to sell this practice or a portion of this practice ever occurs, any qualified potential purchasers may be granted access as part of due diligence process to patient information, in order to verify information related to the sale. If this ever occurs, we will take necessary steps to ensure that the prospective purchaser protects any personal information, as we have done.

Regulatory

The College of Alberta Denturists regulates all Denturists in the Province of Alberta and as part of their regulatory function, may inspect our records and interview our staff in the process of their duties.

Consent

I hereby authorize and consent to the collection, use and disclosure of personal information concerning myself with regards to the above purposes, dated at the City/Town of **Lloydminster** in the Province of Alberta, on the _____ day of _____, 20____.

_____ _____

(Patient/Guardian Name) (Patient /Guardian Signature)

Lloydminster Denture Clinic Inc.

124 4402 52 Avenue
Lloydminster, Alberta, T9V 0Y9

Dental Insurance Company Information Form

Patient Name: _____
Last First

Primary Insurance Company

Company Name: _____ Policy Number: _____
Address: _____ Group Number: _____
_____ Class: _____

Subscriber: _____
☐ Patient Last First ID Number: _____

Subscriber Date of Birth: _____ Place of Employment: _____
MM/DD/YYYY

Subscriber Phone: _____ Coverage (if known) _____ %

Additional Information:

Secondary Insurance Company

Company Name: _____ Policy Number: _____
Address: _____ Group Number: _____
_____ Class: _____

Subscriber: _____
☐ Patient Last First ID Number: _____

Subscriber Date of Birth: _____ Place of Employment: _____
MM/DD/YYYY

Subscriber Phone: _____ Coverage (if known) _____ %

Additional Information:

Additional Insurance Company

Company Name: _____ Policy Number: _____
Address: _____ Group Number: _____
_____ Class: _____

Subscriber: _____
☐ Patient Last First ID Number: _____

Subscriber Date of Birth: _____ Place of Employment: _____
MM/DD/YYYY

Subscriber Phone: _____ Coverage (if known) _____ %

Additional Information:

Method of Payment for non-insured portion(s)

☐ Invoice Patient/Guardian ☐ Credit Card on file and authorized ☐ Financial Terms Agreement on file

Lloydminster Denture Clinic Inc.
124 4402 52 Avenue
Lloydminster, Alberta, T9V 0Y9

Office Use Only

Medical History Alert Numbers: _____

Dental History Alert Numbers: _____

Personal Information: Please Print or place an "X" into the appropriate box(es)

Date: _____ MM/DD/YYYY

Name: _____
Last First Second Used

Date of Birth _____ MM/DD/YYYY Gender: ☐ Female ☐ Male

Home Address: _____ Home Phone: _____

City: _____ Work Phone: _____

Province: _____

Postal Code: _____ Cellular Phone: _____

Home Email: _____ Work Email: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Previous Denturist: _____ Phone: _____

Hygienist: _____ Phone: _____

Referred by: _____ Profession/Relation: _____ Phone: _____

Legal Guardian (if applicable): _____ Contact Number: _____

In Case of Emergency, contact: _____ Contact Number: _____

Relationship: _____ Cellular Number: _____

Your Occupation: _____

Your Living Environment:

Do you require medical devices or equipment such as oxygen, walker, cane, etc? …… ☐ Yes ☐ No

If yes, please describe: _____

Your Personal Accommodation ☐ Private Residence ☐ Multifamily dwelling ☐ Assisted Living ☐ Nursing Home

Individual Responsible For Account: ☐ Patient ☐ Guardian

(For insurance, complete an insurance information form)

Patient Name: **Date:** MM/DD/YYY

Medical Health History

1. Are you currently under the care of a physician? …….. ☐ Yes ☐ No
   If yes, what for?

2. Have you ever had any serious illness or been hospitalized? ……..... ☐ Yes ☐ No
   If yes, what for?

3. Please place an "X" into the appropriate box for the listed health issues. Indicate yes if you have had the condition even if you do not currently have that condition.

YES	NO		YES	NO	
☐	☐	Alcohol problems:	☐	☐	HIV / AIDS:
☐	☐	Drug Dependency- Specify:	☐	☐	Sexual Transmitted disease:
☐	☐	Environmental Allergies. Specify:	☐	☐	Immune Deficiency:
☐	☐	Food Allergies. Specify:	☐	☐	Herpes Virus (cold sores) :
☐	☐	Latex Allergy:			
☐	☐	Other Allergies. Specify:	☐	☐	Kidney Disease:
			☐	☐	Kidney Stones:
☐	☐	Asthma:			
☐	☐	Chronic Obstructive Pulmonary Disease:	☐	☐	Heart Attack:
☐	☐	Difficulty breathing:	☐	☐	Heart Disease:
☐	☐	Emphysema:	☐	☐	Rheumatic Fever:
☐	☐	Tuberculosis:	☐	☐	Heart Murmur:
			☐	☐	Heart Surgery:
☐	☐	Hepatitis A:	☐	☐	Artificial Heart Valve:
☐	☐	Hepatitis B:	☐	☐	Pacemaker:
☐	☐	Hepatitis C:	☐	☐	Angina pectoris:
☐	☐	Other Liver Disease: Specify:			
			☐	☐	Cholesterol problems:
☐	☐	Arthritis:	☐	☐	High Blood Pressure:
☐	☐	Artificial Joint replacement- Specify:	☐	☐	Low Blood Pressure:
			☐	☐	Bleeding Disorder/Haemophilia:
			☐	☐	Stroke:
☐	☐	Cancer. Specify:			
☐	☐	Chemotherapy/Radiation therapy:	☐	☐	Nervousness/Psychiatric condition:
☐	☐	Diabetes Type 1:	☐	☐	Organ Transplant : If yes, specify:
☐	☐	Diabetes Type 2:			
☐	☐	Eating disorder. If yes: ☐anorexia ☐bulimia	☐	☐	Thyroid Disease. If yes: ☐ Hyper ☐Hypo
☐	☐	Epilepsy or Seizures:	☐	☐	Surgeries- specify:
☐	☐	Dizziness/fainting:			
	☐	Other. Specify:			

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4. Have you ever experienced a bad reaction to any of the following medications:

Medication	Yes	No	Never Used	Medication	Yes	No	Never Used
Anaesthetic	☐	☐	☐	Penicillin	☐	☐	☐
Barbiturates (sleeping pills)	☐	☐	☐	Sulphonamides (sulpha)	☐	☐	☐
Codeine	☐	☐	☐	Tranquilizers	☐	☐	☐
Cortisone (steroids)	☐	☐	☐				
Other- please list:	☐						

5. Are you taking any medications, over the counter medications or herbal remedies? …….. ☐ Yes ☐ No
   If yes, what?

   If yes, what for?

6. Are you allergic to any foods, metals or latex? ……..……..…. ☐ Yes ☐ No
   If yes, please list:

7. Have you recently lost or gained a significant amount of weight? …….. ☐ Yes ☐ No
If yes, how much? ……..……..... Gained: _____kg/lbs Lost: _____kg/lbs

8. Do you smoke or use chewing tobacco? ……. ☐ Yes ☐ No
If yes, which and for how long?

9. Do you frequently have indigestion? …… ☐ Yes ☐ No

10. If yes to question #9, do you take anything for the indigestion? …… ☐ Yes ☐ No
If yes, what do you take?

11. Are you pregnant? ……. ☐ Yes ☐ No
☐ NA : Male

12. Do you have any other health issues which have not been addressed above?…….……... ☐ Yes ☐ No
If yes, please list:

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Additional Notes related to Responses on the Medical History

Question Number	Notes

Patient Name: **Date:** MM/DD/YYY

Dental Health History **Please place an "X" into the appropriate box or provide your written response**

1. When was your last dental visit? ……..…….

2. What procedures did you have done at that visit? ……..…

3. Have you had any complications following a dental procedure? ..... ☐ Yes ☐ No
   If yes, please explain

4. Have you had dental x-rays done in the last two (2) years? ……..……..... ☐ Yes ☐ No

5. Do you have any dental work ongoing at this time? ……..……..……... ☐ Yes ☐ No

6. Do you have any outstanding dental work to be done? ……..……... ☐ Yes ☐ No
   If yes, what procedures need to be done?

7. Have you had any complications following a dental procedure? ……..... ☐ Yes ☐ No
   If yes, please specify:

8. Do you have any sensitive teeth (if applicable)? ……. ☐ Yes ☐ No

9. Do your gums bleed (if applicable)? ……..... ☐ Yes ☐ No

10. Do you normally have a bad taste in your mouth?..…… ☐ Yes ☐ No

11. Do you normally have an unpleasant odour/taste in your mouth? ……... ☐ Yes ☐ No

12. Do you have any pain in your jaw joint? ……..... ☐ Yes ☐ No

13. Do you clench or grind your teeth? .....…. ☐ Yes ☐ No

14. Do you have dental implants? ……..... ☐ Yes ☐ No

15. Have you ever had an accident or had trauma/injury to your neck or jaws? ..... ☐ Yes ☐ No
    If yes, specify:

16. Do you have any pain or numbness in your head, neck or jaws? ……... ☐ Yes ☐ No
    If yes, specify:

17. Do you have any sore spots or anomalies in your mouth? ……..... ☐ Yes ☐ No

18. Do you have any habits which affect your mouth such as mouth breathing, chewing objects, chewing nails, etc? ……... ☐ Yes ☐ No
    If yes, specify:

19. Have you been diagnosed with Sleep Apnea? ……..……..... ☐ Yes ☐ No
    If yes, by who? Phone:

20. Do you have any other dental health issues which have not been addressed above? …… ☐ Yes ☐ No
    If yes, please specify:

Complete the following questions only if you have some or all of your natural teeth

21. How often do you brush your teeth? ☐ Daily ☐ Weekly ☐ Other (specify)

22. How often do you floss your teeth? ☐ Daily ☐ Weekly ☐ Other (specify)

23. How often do you see a Hygienist? ☐ Yearly ☐ Bi-Yearly ☐ Other (specify)

Complete the following questions only if you have a denture or dentures

24. What type of dentures do you have? (complete or partial) Complete: Upper: ☐ Lower: ☐ Partial: Upper: ☐ Lower: ☐

25. When were your dentures made?..... Upper: _____ (year) Lower: _____ (year)

26. Who provided you with the dentures? ..... Upper: _____ ☐ Unknown/Prefer not to say Lower: _____

27. Do your gums get sores under your denture(s)? ..... Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No
If yes, how often ☐ Daily ☐ Weekly ☐ Occasionally ☐ Other (Specify): _____

28. Do you brush your gums under your denture(s)? ..... Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No

29. Do you wear your denture(s) at night (if applicable)? ..... Upper ☐ Yes ☐ No Lower ☐ Yes ☐ No

30. How many dentures have you had (if applicable)? ..... Upper: _____ Lower: _____

31. Are you happy with the appearance of your dentures? ..... ☐ Yes ☐ No

32. Do you have problems eating any particular types of food? ..... ☐ Yes ☐ No

33. Do you use denture adhesives? ..... ☐ Yes ☐ No

34. Have the benefits of dental implants been discussed with you? ..... ☐ Yes ☐ No

"I the undersigned, hereby certify that all of the medical and dental information provided on this form to be true to the best of my knowledge and that I have not knowingly omitted any information. I also consent to my family physician/family dentist being contacted, if necessary, to obtain further information or clarification of medical/dental conditions as is necessary for my denturist treatment."

Dated this ____ day of _____, 20___.

_____
Patient Signature

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Notes related to Responses on the Dental History

Question Number	Notes

The Medical and Dental History has been reviewed by myself and discussed with the patient:

Practitioner Signature:	