WELCOME TO OUR PRACTICE

On behalf of the entire team at Vista Dental Care, let us welcome you to our practice. We are grateful that you have chosen us to meet your dental needs, and trust that you will find your experience in our office to be pleasant, professional and extraordinary. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long lasting, and to exceed all your expectations. We use the latest technology and techniques our profession has to offer. Our greatest strength lies in the unequaled advanced training in cosmetic and reconstructive dentistry we have received.

In order to better serve you, we are enclosing in the Welcome Packet several important documents that will assist you in making your transition to our office as smooth as possible. Please read each one carefully so that you can become familiar with our practice philosophy and policies. We are happy to answer questions you may have at any time.

Please find the enclosed Registration and Medical History that should be filled out prior to your first appointment with us.

Be sure to visit our website at vistadentalcare.ca. We look forward to serving all your dental need for you and your family.

Your truly for better dental health,

Dr. Chad Aitken, D.M.D

280-5201 43rd Street Red Deer AB T4N1C7 (403)347-1525
Vistadentalcare.ca

APPOINTMENT AGREEMENT

At Vista Dental Care, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant then any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily.

Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy call one to two days prior to your appointment.

If you find that you cannot keep your appointment, we do require a minimum notice of 48 hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 hours, you will be subject to a $50 late cancellation charge.

We truly appreciate your understanding. Our goal at Vista Dental Care is to be your partner in health and to assist you in keeping your teeth for a lifetime.

By signing below, I agree to fulfill my obligation as a patient at Vista Dental Care and agree to the "broken appointment" fee should I not give proper notification.

_____ _____

Signature of patient or responsible party Date

280-5201 43rd Street Red Deer AB T4N1C7 (403)347-1525
Vistadentalcare.ca

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your personal health information to carry out our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We serve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (403) 347-1525 or by mailing us at 280-5201 43 Street, Red Deer, AB T4N 1C7.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the consents of this Consent form and your Notice of Privacy Practices. I understand that signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a person representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER TO SIGN IT.

Patient:

Mr./Mrs./Ms._____

Surname First Middle

Date of Birth: _____ Emergency Contact: _____ Phone:_____

Address: _____City/Prov:_____Postal Code: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ Employer:_____ Occupation:_____

Family Doctor:_____ Phone:_____

How did you hear about us? _____ Family/Friend Referral(name): _____

Do you have Dental Insurance Coverage? Yes No If yes, please provide us with benefits card

Medical History

1. Are you currently in good health? Yes No
   If no, please explain: _____
2. Are you currently taking any medication, supplements or drugs: Yes No
   If yes, please list: _____
3. Are you allergic to or ever had a reaction to any of the following: (please circle)
   Penicillin Local Anesthetic ("freezing") Sulpha Drugs Codiene Aspirin (ASA) Latex
   Other_____
4. Are you under the regular care of a physician? Yes No
   If yes, please explain: _____
5. Do you bleed more or longer than normal after a cut, bruise, surgery or previous tooth removal?
   Yes No If yes, please explain: _____
6. Have you ever had a serious illness or operation? Yes No
7. Do you now have or ever had any of the following conditions? Yes No

❑ Heart Trouble or Stroke	❑ Tumors or Cancer	❑ Diabetes	❑ Thyroid Disease	❑ Epilepsy or Seizure
❑ Breathing problems	❑ Hepatitis or Liver Disease	❑ Blood Disorders	❑ HIV Positive	❑ Hormonal Disorder
❑ Rheumatic Fever	❑ Tuberculosis	❑ Heart Murmur	❑ Kidney Disease	
❑ High or Low blood pressure	❑ Venereal Disease	❑ Arthritis	❑ Mental Illness	

8. Women- Are you pregnant? Yes No If yes, which Trimester? _____
9. Do you smoke? Yes No If yes, how many per day? _____
10. Is there anything else we should know about your health?
    If yes, please explain: _____

Dental History

1. What dental condition(s) concerns you at present? _____
2. When was your last dental check-up and cleaning? _____
3. Were x-rays taken at that time? Yes No
4. Do you have any sore or aching or sensitive teeth? Yes No
5. Have you noticed any signs of the following? (Please circle)
   Bleeding gums Swelling of gums Gum ache Receding gums Loose teeth Drifting teeth
6. Do you have any clicking, popping or pain in your jaw Yes No
7. Are you aware if any clenching or grinding of your teeth? Yes No
8. Do you have any missing teeth that you feel should be replaced? Yes No
9. Would you like to improve the appearance of your teeth? Yes No
10. Do you floss your teeth? Yes No
11. Have you had any complication with previous dental treatment? Yes No
    If yes, please explain: _____
12. How do you rate yourself as dental patient? Calm Slightly Nervous Very Apprehensive

I hereby certify that the Medical and Dental histories are accurate and complete to the best of the knowledge. I consent to the performing of the dental oral surgery procedure agreed to be necessary or advisable, including the use of general or local anesthetic or any drugs indicated, and I will assume responsibility for fees associated with these procedures. I also consent to the collection, use, retention and disclosure of personal information as required for my own and my dependents dental care.

Date: _____ Patient/Parent Signature: _____