South Edmonton Prosthodontics
Your Smile. Our Specialty.

Confidential Patient Questionnaire

kucey dental group

The following information is required to enable us to provide you with the best possible dental care. All information is strictly private, and is protected by the doctor-patient confidentiality. We are committed to protecting our patient's personal information with collection, use, and retention of personal information. We will not release information from our office without formal consent. The dentist will review the questions and explain any that you do not understand. Please fill in the entire form.

For Office Use Only
ASA 1 2 3 Other BMI

Personal Information

Today's Date: _____/_____/_____ DD/MM/YY

Title: Mr. / Mrs. / Ms. / Dr. / Other _____

Surname: _____ First Name: _____ Initials: _____

Date of Birth: _____ DD/MM/YY Height: _____ Weight: _____ Occupation: _____

Home Address: _____ City: _____ Postal Code: _____

Phone: Home _____ Work _____ Mobile _____

Best Number to Contact: Home Work Mobile Email: _____

Marital Status: _____ Name of Spouse: _____ Occupation: _____

In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____ AHC#: _____

Medical Specialist 1: _____ Specialty: _____ Phone: _____

Last Physical Examination: _____ Findings: _____

Regular Dentist: _____ Phone: _____ Last Visit Date: _____

May we request previous records: Yes No Who may we thank for referring you? _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ DOB: _____ Policy Holder: _____ DOB: _____

Group: _____ ID: _____ Group: _____ ID: _____

Medical History

1. Are you being treated for any medical condition at the present time or within the last year? ❑ Yes ❑ No
   Please List: _____
2. Has there been any change to your general health in the past year? ❑ Yes ❑ No
   Please Explain: _____
3. Are you taking prescription medications, non-prescription drugs or herbal supplements of any kind? ❑ Yes ❑ No
   Please List: _____
4. Are you allergic to or react adversely to any drug, medicine, injections, or OTHER substance (foods or environmental)?
   (ie. local anesthetic "Freezing", general anesthetic, Penicillin or other antibiotics, barbiturates, sedatives, analgesics (painkillers)?
   Please List: _____
5. Have you ever been advised by your doctor to take antibiotics before dental treatment? ❑ Yes ❑ No
6. Do you have any conditions that could affect your immune system? ❑ Yes ❑ No
   (ie. leukemia, radiotherapy, chemotherapy, HIV infection, AIDS)

7. Have you ever been hospitalized for any illness or operations? ❑ Yes ❑ No

Please List: _____

8. Do you have (or have you had) any of the following conditions or problems? Please check all that apply.

❑	Rheumatic Fever	❑	Lung/Asthma/Breathing Disorder	❑	Bone, Muscle or Joint Disorder
❑	Rheumatic Heart Disease	❑	Tuberculosis (Latent / Active)	❑	Bisphosphonates
❑	Heart Trouble/Disease	❑	Seizures (eg: Epilepsy)	❑	Cancer
❑	Heart Attack	❑	Fainting Spells	❑	Gastrointestinal /Ulcers/GERD
❑	Heart Surgery	❑	Nervous Disorder	❑	Arthritis
❑	Arteriosclerosis	❑	Diabetes Type I / II	❑	Bruising/Bleeding/Blood Disorder
❑	Heart Murmur	❑	Endocrine / Genetic Disorder	❑	Anemia/Anticoagulants
❑	Congenital Heart Lesions	❑	Hormone Therapy	❑	Skin Rash
❑	Prosthetic Heart Valve	❑	Thyroid Disease	❑	Delayed Healing
❑	Pacemaker	❑	Steroid Therapy	❑	Sensitivity to Metals
❑	High Blood Pressure	❑	Diet Pill Therapy	❑	Chicken Pox / Shingles / Measles
❑	Chest Pains	❑	Kidney Disease/Disorder	❑	Hay Fever
❑	Stroke	❑	Jaundice/Liver Disease	❑	Allergy to Latex
❑	Sleep Apnea	❑	Alcoholism/Substance Abuse	❑	Cosmetic Surgery
❑	Shortness of Breath	❑	Joint Replacement/Prosthetic	❑	Other: _____

9. Are there any conditions or disease not previously listed that you have or have had? ❑ Yes ❑ No

Please List: _____

10. Have you gained or lost excessive weight recently? ❑ Yes ❑ No If so, how much? _____

11. Are you on a special diet? (ie. gluten free) ❑ Yes ❑ No Please explain: _____

12. To the best of your knowledge, have you come in contact with HIV, AIDS, or Hepatitis? ❑ Yes ❑ No

13. Do you have any unhealed injuries, inflamed areas, growth, or sore spots in or around your mouth? ❑ Yes ❑ No

14. Is there a family history of any diseases or medical problems? (ie. diabetes, cancer, heart disease) ❑ Yes ❑ No

15. Tobacco: Do you smoke or use chew / vaping (e-cigarette) products? If so, how much/day: _____ ❑ Yes ❑ No
Have you quit smoking? ❑ Yes ❑ No Congratulations! When? _____

16. Recreational drugs/marijuana: Do you smoke / vaping / ingest? If so, how much/day: _____ ❑ Yes ❑ No

17. Do you have a history of facial trauma, TMD, or motor vehicle accident ❑ Yes ❑ No

18. For women only: Are you breast-feeding or pregnant? Due Date: _____ (DD/MM/YY) ❑ Yes ❑ No

19. On a scale of 1 to 4, (1 being calm - 4 being very afraid) how comfortable are you receiving dental treatment?

calm 1 2 3 4 very afraid

The above represents a current and accurate health history and personal information. I hereby consent to examination, necessary tests or records, photographs, medication, local anesthesia, sedation, and recommended treatments as explained by the Doctor which includes explanation of the feasible treatment alternatives. I further consent to the taking of photographs, or other tests showing the condition of my mouth or my treatments for the purpose of documentation, my education, or for dental, scientific and educational purposes.

I understand and agree that payment of professional services is due and payable at the time of service. I am responsible for any additional legal fees, collection costs and interest incurred in collecting the balance due. I authorize electronic transmission of dental claims on my behalf as required. A 24% per annum interest will be charged and paid by me on all accounts or portions thereof unpaid for over 30 days until the account, plus interest, is fully paid.

Signature: _____ Date: _____ Witness: _____

Signature: _____ Date: _____ Witness: _____

Signature: _____ Date: _____ Witness: _____

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Implant, Esthetic & Reconstructive Dentistry

Mission Statement

Our mission at South Edmonton Prosthodontics and Kucey Dental Group 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 & College. 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 the sensitive nature of your privacy. 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. Brian Kucey or Dr. Elena Hernandez-Kucey 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.

Patient's Signature:_____ Date:_____

Witness Signature_____ Date:_____

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AUTHORITY TO RELEASE RECORDS

Other than correspondence with other health care providers involved in your care, we require your written consent to release information.

I, _____, hereby authorize Dr_____to release and deliver any and all information, records, x-rays and other data in their possession or control regarding medical history, treatment, physical conditions, of diagnosis pertaining to the undersigned.

_____ and _____
(patient name) (patient name)

to Dr. Brian Kucey and Dr. Elena Hernandez-Kucey

EMAIL TO : info@kuceydental.ca

Dated this _____ day of, _____
(month)

_____ _____
Patient Signature Witness Signature