# hucal&edwards

ORTHODONTICS

500, 3020 – 22nd Street, Red Deer, Alberta T4R 3J5 | Ph: 403.358.3330

## *Welcome to Our Office*

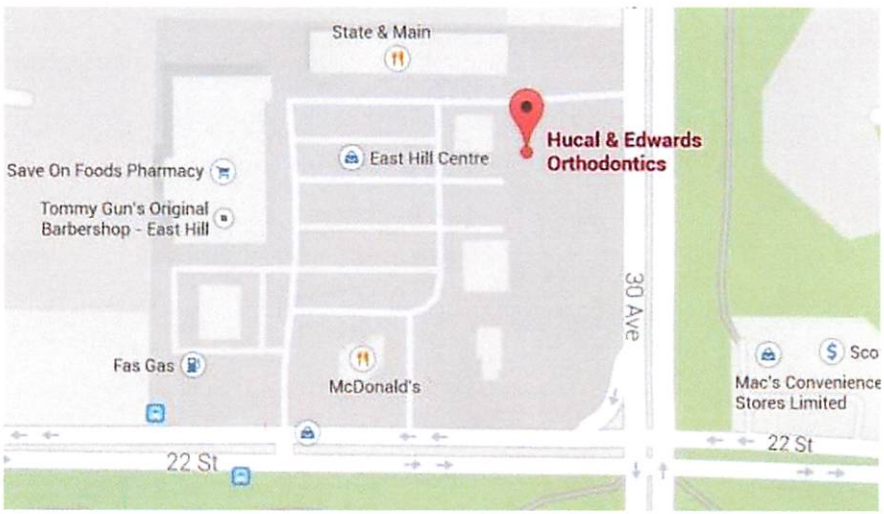
*To help us prepare, we would ask that you complete the enclosed medical-dental form as well as the privacy form. Once complete, kindly return to us either by email to amanda@hucalandedwards.com or by regular mail. All the information contained therein will be held in confidence and will allow us the opportunity to fully understand your health history and orthodontic concerns.*

*If you have any questions regarding the form or your upcoming consultation, please do not hesitate to call us (403.358.3330) as we are happy to give you any assistance.*

*As indicated during our initial telephone conversation, the consultation will require approximately 1 hour. During this time Dr. Hucal or Dr. Edwards will complete a thorough orthodontic evaluation and recommend appropriate treatment. The fee for this consultation is $100.00 and is due the day of your appointment. A receipt will be given to you for insurance reimbursement as we do not accept direct payment from insurance companies.*

*Please note; we will contact you prior to your appointment and request verbal confirmation of your consultation.*

*Sincerely,*
*Amanda Phipps*
*Initial Exam Coordinator*
*Hucal & Edwards Orthodontics*



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500, 3020 - 22nd Street, Red Deer, Alberta T4R 3J5
Phone: (403) 358-3330 Fax: (403) 358-3074

***Patient Name*** _____
Last First Initial

Age _____ Date of Birth _____ Gender _____

Billing Party Email _____

Address _____

School _____ Grade _____

Best telephone number to call for appointments (During business hours) _____

In the event that we are unable to contact parents who would we contact in an emergency situation? _____

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***Mother's Name*** _____
Last First Initial

Home Address _____ Home Tel.# ( ) _____

Employed by _____ Office Tel.# ( ) _____

Does mother have Orthodontic Insurance? _____ Yes _____ No
If yes, please complete the Insurance Page on the back of this booklet.

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***Father's Name*** _____
Last First Initial

Home Address _____ Home Tel.# ( ) _____

Employed by _____ Office Tel.# ( ) _____

Does father have Orthodontic Insurance? _____ Yes _____ No
If yes, please complete the Insurance Page on the back of this booklet.

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Patient's Family Dentist _____ Tel. # ( ) _____

Patient's Family Physician _____ Tel. # ( ) _____

Whom may we thank for referring you to our office? _____

**Dr. Ivan Hucal**
DMD, MSc (Ortho)
certified specialist in orthodontics

**Dr. Ryan Edwards**
DDS, MSc (Ortho)
certified specialist in orthodontics

**MEDICAL HISTORY:**

Have you had or do you have any of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Rheumatic Fever | ❑ | ❑ | Persistent Headaches | ❑ | ❑ |
| Heart Murmur | ❑ | ❑ | Neck Pains | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ | Nerve or Brain Disease | ❑ | ❑ |
| Heart Attack / Stroke | ❑ | ❑ | Migraine | ❑ | ❑ |
| Blood Vessel Disease | ❑ | ❑ | Epilepsy | ❑ | ❑ |
| Blood Disorder | ❑ | ❑ | Mental Health Problems | ❑ | ❑ |
| AIDS / HIV Infection | ❑ | ❑ | Bone Disorders | ❑ | ❑ |
| Hepatitis | ❑ | ❑ | Arthritis (Any type) | ❑ | ❑ |
| Diabetes | ❑ | ❑ | Sleep Apnea | ❑ | ❑ |
| Ulcers | ❑ | ❑ | Ear Disorder | ❑ | ❑ |
| Herpes (Any type) | ❑ | ❑ | Sinus Infection | ❑ | ❑ |
| Psoriasis | ❑ | ❑ | Swollen Glands | ❑ | ❑ |
| Cancer | ❑ | ❑ | Allergies | ❑ | ❑ |

Comments _____

Please list any other significant information about your medical history: _____

_____

_____

**Yes** **No**

❑ ❑ Is patient under a physician's care at present? If yes, reason _____

❑ ❑ Is patient presently, or have you ever been, under the care of a psychiatrist or psychologist?
If yes, describe _____

❑ ❑ Is patient currently taking any medication? If yes, describe _____

❑ ❑ Is the patient allergic to any medications? (IE: Aspirin, Penicillin, etc.) If yes, what? _____

❑ ❑ Has patient ever had any general anaesthesia? When?

_____

**DENTAL HISTORY:**

**Yes** **No**

❑ ❑ Do any of your teeth hurt? If yes, upper right ❑ upper left ❑ lower right ❑ lower left ❑

❑ ❑ Have any wisdom teeth been removed? How many? _____

❑ ❑ Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe _____

❑ ❑ Have you ever had any previous orthodontic treatment (braces)? If yes, when _____
If yes, doctor's name and address _____

❑ ❑ Have there been any injuries to your mouth or teeth? If yes, describe _____

❑ ❑ Have you ever had any injury in the head and neck area? If yes, describe _____

❑ ❑ Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe _____

_____

❑ ❑ Have you ever had any surgery in the head and neck area? If yes, describe _____

❑ ❑ Do you clench or grind your teeth? If yes, while sleeping ❑ under stress ❑ Other _____

❑ ❑ Do your jaw muscles ever feel tired? If yes, when _____

❑ ❑ Do you ever notice soreness, tightness or pain in the muscles around the jaws and face? If yes, describe _____

_____

❑ ❑ Does it hurt to chew? If yes, where does it hurt? _____

❑ ❑ Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

| | Right | Left | Since when | During what activity |
|---|---|---|---|---|
| ❑ Clicking: | ❑ | ❑ | _____ | _____ |
| ❑ Grating: | ❑ | ❑ | _____ | _____ |

Did these joint sounds begin gradually or suddenly? ❑ gradually ❑ suddenly

❑ ❑ Was there some specific event that started the joint sounds? If yes, describe _____

❑ ❑ Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____

Yes No

- ❑ ❑ Have your jaws ever "locked" closed? If yes, describe _____
- ❑ ❑ Have your jaws ever "locked" wide open? If yes, describe _____
- ❑ ❑ Do you have pain in your jaw joints? If yes, right ❑ left ❑ Since when? _____
  Did your pain start gradually or suddenly? ❑ gradually ❑ suddenly
  During what activity? _____ Describe nature of pain _____
  What increases the pain? _____ What decreases the pain? _____

Do you have any of the following habits?

Yes No

- ❑ ❑ Finger / Thumbsucking
- ❑ ❑ Lip Biting
- ❑ ❑ Nail Biting
- ❑ ❑ Gum Chewing
- ❑ ❑ Ice Chewing

**GROWTH AND DEVELOPMENT:**

- ❑ ❑ Has patient reached adolescent growth?
- ❑ ❑ Girls - Has monthly cycle started yet? If so, when _____
- ❑ ❑ Boys - Has voice changed yet? If so, when _____
- ❑ ❑ Is the patient adopted? Does the patient know? Yes ❑ No ❑
- ❑ ❑ Are there any learning disabilities? If yes, explain _____
  Patient's present height _____ Expected height of patient _____
  Father's height _____ Mother's height _____
- ❑ ❑ Are there other children in the family?
  Names and Ages _____
- ❑ ❑ Has any other member of the family had orthodontic treatment?
- ❑ ❑ Has any other member of the family been a patient in this office?
  Name _____

Please describe why you sought this consultation _____

- ❑ ❑ Has patient ever been treated for this problem before? If yes, please describe the diagnosis and treatment _____
  _____

Any information you can give me concerning your child will be appreciated. The more we know about each patient, the more help we can give in managing the orthodontic treatment, both at home and in the office. Also, please include special interests and hobbies:

_____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to the patient's clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination.

_____ _____

(Signature of Responsible Adult) Date

Doctor's Notes _____

_____

_____

_____

_____

_____ _____

(Doctor's Signature) Date

*see over - page 4 →*

# INSURANCE INFORMATION

## *Primary Coverage*

**Policy Holder's Name** _____

Address _____

**Name of Employer** _____

Address _____

**Name of Insurance Company** _____

Group or Plan # _____ Cert. / Sec. _____

ID # of employee _____ SIN # _____

Birth Date of Employee _____

ID # of dependant _____

**Patient's Name** _____

## *Secondary Coverage (if applicable)*

**Policy Holder's Name** _____

Address _____

**Name of Employer** _____

Address _____

**Name of Insurance Company** _____

Group or Plan # _____ Cert. / Sec. _____

ID # of employee _____ SIN # _____

Birth Date of Employee _____

ID # of dependant _____

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# PERSONAL INFORMATION CONSENT FORM

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances described in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses. (Collectively referred to as "Contact Information"). Contact Information is collected and used for the following purposes:

- **To open and update patient files.**
- **To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts.**
- **To process claims for payment or reimbursement from third-party health benefit providers and insurance companies**
- **To send reminders to patients concerning the need for further dental examination or treatment.**
- **To send patients informational material about our dental practice.**

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim or insurance pre-determination on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services.

We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information") Patient's Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patient's Medical Information is disclosed:

- **To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement for payment of all or part of the cost of dental treatment or has asked us to submit a claim or an insurance pre-determination on the patient's behalf.**
- **To other dentists and/or dental specialists, where we are seeking a second opinion and the patient has given us consent to obtain the second opinion.**
- **To other dentists and/or other dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment.**
- **To other dentists and/or other dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion.**
- **To other health care professionals such as physicians, with the consent of the patient, has been referred by us to the other health care professional for either a second opinion or treatment.**

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

**I consent to the collection, use and disclosure of my personal information as set out above.**

**Patients Name**_____

| | | |
|---|---|---|
| **Date** | **Print Name** | **Signature** |