Seton Smiles ORTHODONTICS

Seton Smiles Orthodontics

Suite 112 – 3883 Front Street SE
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403-250-5830 • setonsmiles.ca

Welcome to

Seton Smiles Orthodontics

We have you scheduled for your complimentary orthodontic consultation with Dr. Mostafa Altalibi. If, you haven't been to our Seton location before, we are located across the street from the **South Health Campus Hospital, Suite 112-3883 Front Street SE**.

You can park on the street out front or there is parking in the rear of the building. It is a paid parking area, please **DO NOT pay**; come in with your licence plate number and we will validate your parking for you at each visit.

Attached are your new patient intake forms, please fill out and send back to our office prior to your scheduled visit.

If you have any questions prior to your appointment, please do not hesitate to contact our office.

Our team looks forward to meeting you!

Insurance Information

Let us know if you have any questions

Would you like us to direct bill to your insurance?

☐ Yes – Please Fill out Plan information and continue back side of page.

☐ No – Please Sign Below

Primary Insurance Plan:

Plan Member Name: _____Birthdate(M/D/Y): _____

Employer Name:_____

Insurance Company: _____

Group Policy Number: _____

Subscriber ID: _____

Secondary Insurance Plan:

Plan Member Name: _____Birthdate(M/D/Y): _____

Employer Name:_____

Insurance Company: _____

Group Policy Number: _____

Subscriber ID: _____

Please be aware that there will be a 25% deposit taken day of the appointment if the insurance claim does not give us a break down of coverage

_____ _____ _____

Name Signature Date

Medical History

Family Physician: _____ Date of last check up: _____

Are you currently under medical care? Y ☐ N ☐ If yes, explain: _____

Do you have any drug allergies? Y ☐ N ☐ If yes, explain: _____

Are you taking any medications? Y ☐ N ☐ Please List: _____

Indicate any history of: (Please check all that apply)

☐Latex allergy ☐Epilepsy or seizures ☐Asthma ☐Diabetes ☐Nickel/metal allergy
☐Rheumatic fever ☐ Heart problems/murmur ☐Headaches ☐Hereditary problems
☐Anemia ☐Hepatitis ☐HIV Positive ☐Prolonged bleeding ☐Kidney or liver disease

Other: _____

Dental History

Family Dentist name: _____ Dental Clinic Name:_____

Date of last Dental visit: _____ Were x-rays taken? Y☐ N☐

Have you ever seen an orthodontist before? _____

Indicate any history of: (Please check all that apply)

☐Pain, clicking or popping while chewing, yawning or wide opening?
☐Do you grind or clench your teeth?
☐Have you been informed of missing or extra teeth?
☐Tonsils/adenoids removed?
☐Severe injuries to face or teeth?
☐Habits? eg: Nail biting, cheek biting

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* ("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 forms for patient reimbursement from third-party health benefit providers and private insurance companies
- to send reminders to patients concerning the need for further dental and/or orthodontic examination or treatment
- to send patients informational material about our orthodontic practice.

Contact Information is disclosed to 3rd party health benefit providers and insurance companies where the patient/ parent has submitted a claim for reimbursement and has asked us to communicate directly with the 3rd party 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 treatment history* ("Medical Information"). Patient Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed:

- to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement
- to other dentists and dental specialists, where we are seeking an opinion, and the patient has consented to us obtaining the opinion
- to other dentists and dental specialists if the patient, with their consent, has been referred to the other dentist or dental specialist for treatment
- to other dentists and dental specialists where those dentists or dental specialists have asked us, with the consent of the patient, to provide a 2nd opinion
- to other health care professionals such as physicians if the patient, with their consent, has been referred by us to the other health care professional for either a 2nd opinion or treatment.

Seton Smiles is proud to participate in social media outlets to keep in touch with our patients. We love to share milestones, welcome new patients, and celebrate all the beautiful smiles with the wonderful people that walk through our door, and with the local community. If you wish to revoke your consent to post any photos of you or your child while you are in our clinic, please let us know and we would be happy to add a note into your file. We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner.

If we are 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 and dental specialists 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 hereby give my permission for the use of orthodontic records, including photographs, for the purposes of professional consultations, education or publication in professional journals (No names will be used)

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

I authorize Dr. Mostafa Altalibi to perform a clinical examination and to obtain photographic and radiographic documentation.

Name: _____ Signature: _____ Date: _____