SIMON FRASER DENTAL CENTRE

Patient Information

Patient Name: _____ **E-mail:**_____
(Please Print) LAST First Middle (Preferred Name)

Date of Birth: _____ **Gender:** M / F **Status:** Married /Single/Child **Title:** Dr. / Mr. / Mrs. / Ms. / Miss / Mstr.
Day / Month / Year

Phone (Home): _____ **(Work):** _____ **(Cell):** _____

Address: _____
Apartment # Street

_____
City Province Postal Code

Health Information

Date of last dental visit: _____ Reason for this appointment: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS / HIV
- ☐ Allergies _____
- _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Unusual Reaction to Anesthetic or Freezing

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- What are your expectations or preference from this office?
  _____
- Do you like your smile? ☐ Yes ☐ No?
  If not, please indicate areas of improvement: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you currently on any medications? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Name of Previous Dentist / Dental Office: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X _____ Date: _____
Signature of Patient / Parent or Guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient → Name: _____

☐ Walk-by ☐ SFU ☐ Newspaper ☐ Flyer ☐ Yellow pages ☐ Website ☐ Other: _____

Emergency Contact

Name: _____ Birth Date: _____ Gender: M / F

Relationship: ☐ Spouse ☐ Parent ☐ Friend ☐ Other _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address: _____
Street City Province Postal Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City Province Postal Code

Insurance Information

PRIMARY PLAN

Name of Insured: _____ Date of Birth: _____
Last First MI

Insured's Employer Name & Phone # :_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company Name: _____ Group # : _____ ID # : _____

Coverage: A: _____% B: _____% (Limit_____) C: _____% (Limit _____) Recall: _____

SECONDARY PLAN

Name of Insured: _____ Date of Birth: _____
Last First MI

Insured's Employer Name & Phone # : _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Company Name: _____ Group # : _____ ID # : _____

Coverage: A: _____% B: _____% (Limit_____) C: _____% (Limit _____) Recall: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for full amount of charges. SFDC does accept assignment from most insurance companies for patient convenience and that he or she is personally responsible for any portion not covered by insurance. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended until a new British Columbia Dental Association General Practitioner' Fee Guide is available or can only be extended for a period of six months from the date of the patient examination if the fee is not available in the new British Columbia Dental Association General Practitioner' Fee Guide.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and my treatment.

Consent for Assignment of Benefits and Electronic Filing: I authorize release; to my dental benefits plan administrator and the Canadian Dental Association, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.

I agree I shall be governed in accordance with the laws of the Province of British Columbia, Canada. I also acknowledge and agree that the Courts of the Province of British Columbia, Canada, shall have the exclusive jurisdiction to deal with any complaints, demands, claims, disputes, causes of actions or proceedings, including whether they are based on alleged breach of contract or alleged negligence arising out of the treatment or service provided to me by the dentists; their employees, associates, staff, or anyone acting under or with them.

I have read the above conditions of treatment and payment and agree to their conditions.

X _____ Date: _____
Signature of Patient / Parent or Guardian