



My Dentist @

We at My Dentist @ Columbia Square look forward to taking care of your oral health care needs and welcome you to our team of professionals. We are committed to doing our very best to achieve a lifetime of optimal health for our patients.

Personal Information

Patients Name (Last, First, Middle Initial): _____

Mr. Mstr. Mrs. Ms. Miss Dr. Birth Date (Day/Month/Year): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (H) _____ (W) _____ Ext. _____ (M) _____

Email: _____ **APPOINTMENTS ARE CONFIRMED VIA EMAIL**

Emergency Contact or Responsible Party if under the age of 18

Name (Last, First): _____ Male Female

Birth Date (D/M/Y): _____ Relationship to Patient: _____

Address (if different from patient) _____

Phone: (H) _____ (W) _____ Ext. _____ (M) _____

Referral Information - Ask about our referral program!

Whom may we thank? Name: _____ Relationship: _____

OR Newspaper Ad/Mail Our Website 123 Dentist Google Search Yellow Pages Clinicbook

Convenient Location to Home, Work or School Other _____

Health History

Date of Last Dental Visit: _____ Reason for Today's Visit: _____

Have you ever had any of the following? (please circle those that apply)

- | | | | |
|---------------------|----------------------|--------------------|----------------------|
| AIDS or HIV | Growths | Dizziness/Fainting | Stomach Problems |
| Hepatitis : | Heart Disease | Epilepsy | Ulcers |
| A B C | Heart Murmur | Stroke | Liver Disease |
| Blood Disease | Pacemaker | Head Injuries | Kidney Disease |
| Anemia | Rheumatic Fever | Codeine Allergy | Arthritis |
| Diabetes | Respiratory Problems | Penicillin Allergy | Artificial Joints |
| High Blood Pressure | Asthma | Latex Allergy | Rheumatism |
| Excessive Bleeding | Tuberculosis | Other Allergies | Glaucoma |
| Cancer: _____ | Jaundice | _____ | Venereal Disease/STD |
| Radiation Treatment | Mental Disorders | Hay Fever | Other _____ |
| Tumors | Nervous Disorders | Sinus Problems | |

- Are you currently taking medication? Yes No
If yes, please explain: _____
- Have you ever had any complications following dental treatment? Yes No
If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the last two years? Yes No
If yes, please explain: _____
- Are you currently under the care of a physician for any medical concerns? Yes No
If yes, please explain: _____
Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____
- **Women:** Are you pregnant? Yes No If Yes, Due Date: _____

Insurance Information

Primary Plan:

Insurance Company _____ Employer Name _____

Policy/Plan Number _____ Certificate/ID Number _____

Policy Holder _____ Birth Date (D/M/Y) _____ Relationship _____

Secondary Plan:

Insurance Company _____ Employer Name _____

Policy/Plan Number _____ Certificate/ID Number _____

Policy Holder _____ Birth Date (D/M/Y) _____ Relationship _____

Ministry of Housing and Social Development (MHSD) – British Columbia

Care Card Number _____

As a convenience to you, Dr. A. Shivji & Dr. S. Fazal Inc. will accept direct assignment from most insurance companies. However, please be aware that if for any reason your claim is rejected, or the full amount is not paid, you are financially responsible for the balance. **The patient portion of the fee is due at the time service is rendered.** Claims billed to insurance not paid within 8 weeks will be billed to the patient. Please notify us immediately of any changes to your dental insurance. **I have read and understood this statement and I agree if my dental plan does not cover 100% of the costs of my dental treatment, I will pay the balance owing as previously arranged or when the services are completed and the account rendered.** Initials _____

NO PLAN

I understand payment is due at the time treatment is rendered. No exceptions. Initials _____

Cancellation Policy

It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. To keep our standard care to a level which best serves your dental needs, we ask that you observe the following:

Our clinic requires a minimum of 2 business days notice if an appointment must be cancelled or rescheduled. A short notice cancelled appointment can adversely affect many other patients: especially those who are suffering or in pain. **If less than 2 business days notice is given to cancel or reschedule and appointment, or no notice is given, a fee of \$75.00 will be assessed.** Exceptions will be made for illness or personal tragedy.

In the event that a patient does not come to their scheduled appointment on a second occasion, the practice may ask that patient to find a new dental practice at which point our administrative staff will be happy to forward the patient's records.

Please note: Insurance companies do not cover any fees associated with missed or cancelled appointments; therefore payment is made the patient's responsibility prior to rescheduling.

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 my next appointment without fail.

By initialing the Insurance Information, I am acknowledging I have read and understood the statement pertaining to my insurance status.

I have read and understood the Cancellation Policy.

Signature _____ Date: _____

(Patient/Parent or Guardian if under 18 years)