VANCOUVER CITY CENTRE DENTAL

Patient Information

Name: _____
Last First MI (Preferred Name)

Address: _____
Street Apt #

_____
City Province Postal Code

Phone: Cell: _____ / Work _____Ext ___ / Home: _____

Email: _____ Date of Birth (DD/MM/YY): _____

Occupation: _____ Employer: _____

Referral Information

☐Patient, friend: _____ ☐Patient, relative: _____

☐Google search ☐Other search engine ☐Facebook ☐Clinicbook ☐YellowPages.ca

☐Specialist/Dr.: _____

☐Ad: _____ ☐Hotel: _____ ☐Other: _____

Communication

I would like to receive appointment reminders by: ☐ E-mail ☐ Text ☐ Phone ☐ Any ☐ Neither

From time to time we may send out e-mails, such as newsletters, containing important health, dental and office news.
I would like to receive these messages (you will always have the option to unsubscribe): ☐ YES ☐ NO ☐ N/A

Insurance Information

1) Relationship to insured: ☐Self ☐Spouse ☐Child ☐Other Insurance Company: _____

Employer: _____ Group/Policy#:_____ Division: ____ ID/Certificate#:_____

If patient is not the insured, please complete the following:

Name of Insured: _____ Date of Birth: _____

2) Relationship to insured: ☐Self ☐Spouse ☐Child ☐Other Plan Name: _____

Employer: _____ Group/Policy#:_____ Division: ____ ID/Certificate#:_____

If patient is not the insured, please complete the following:

Name of Insured: _____ Date of Birth: _____

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MEDICAL HEALTH INFORMATION

PLEASE CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

☐ AIDS/HIV+	☐ Heart Disease	☐ Pacemaker	**ALLERGIES:**
☐ Arthritis	☐ Heart Problems	☐ Respiratory Problems	☐ Anaesthetics
☐ Artificial Joints/Valves	☐ Hepatitis	☐ Rheumatic Fever	☐ Aspirin/Tylenol
☐ Asthma	☐ High Blood Pressure	☐ Stroke	☐ Codeine
☐ Cancer	☐ Kidney Disease	☐ Thyroid Disease	☐ Ibuprofen
☐ Diabetes	☐ Liver Disease	☐ Transmittable Disease	☐ Latex
☐ Epilepsy	☐ Lung Disease	☐ Tumours	☐ Penicillin
☐ Excessive Bleeding	☐ Mental Disorder	☐ Women: Pregnant?	☐ Sulpha
☐ Head/Neck Injury	☐ Osteoporosis		☐ Other _____

- Name of Family Physician: _____ Phone: _____
- What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please provide details: _____
- Are you currently being treated for any illness? ☐ Yes ☐ No
  If yes, please provide details: _____
- Do you smoke? ☐ Yes ☐ No Have you ever been a smoker? ☐ Yes ☐ No
  If yes, please provide details: _____
- Are you taking any prescription medications? ☐ Yes ☐ No Vitamins or herbal remedies? ☐ Yes ☐ No
  If yes, please provide details: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please provide details: _____
- How long has it been since your last dental visit? _____

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 doctor at the next appointment without fail.

Signature of patient, parent or guardian: _____ Date: _____

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Our Financial Policy

Our goal is not to let expense prevent you from receiving the exceptional dental care you deserve.

Fees

Our fees are based on the quality of materials we use and our clinical expertise and experience in performing your needed treatment. At the completion of an appointment payment is expected, unless financial arrangements have been made in advance. Our payment options include cash, debit card, Visa and MasterCard.

After Dr. Suyama has examined you and determined what treatment is needed, he or she will recommend an appropriate treatment plan. We would be happy to discuss your financial arrangement options during your treatment plan consultation or at another time convenient to you. All fee estimates for dental services are valid for a period of six months.

Insurance

Our office understands the value of insurance benefits to our patients. We will complete and file your insurance forms and supply all documentation to maximize your benefits.

Dental plans vary greatly. We encourage our patients to know their plan in order to eliminate disappointment with payment and reimbursement. At Vancouver City Centre Dental, we submit directly to your Insurance Plan – the patient in responsible for their portion at the appointment. We do our utmost to keep on top of Insurance plans – however we do not have a direct relationship with them. Due to privacy laws, it is getting more difficult for us to get all the information we need. When changes happen to your plan we are not advised by your Insurance carrier. Ultimately outstanding balances not paid by your plan are the patient responsibility. Upon request, we will provide a pre-authorization for estimated insurance coverage in advance of treatment to enable patients to prepare their finances accordingly.

Remember, your dental insurance plan is not a treatment plan. The forms, conditions, and percentages of payments are contracted between you, your employer or union, and the insurance company who agreed to pay toward the costs of your dental care, and the specific benefits that *they* have agreed to provide. Only *you and your dentist* can decide the treatment plan that best meets your specific needs and circumstances.

Appointments

We require 2 business days' notice for all scheduling changes. Appointments are valuable blocks of time. When an appointment is missed or cancelled without this notice it prevents us from helping someone else. In order to control costs for all of our patients, we must charge a non-refundable fee of **$100 per scheduled hour for all appointments that are missed or cancelled with less than 2 business days' notice.** Our office will provide you with a courtesy reminder for all appointments booked in advance. Please help us serve you better by keeping all scheduled appointments.

_____ (initials of patient)