SPARWOOD dental clinic

PATIENT REGISTRATION ALL INFORMATION IS CONFIDENTIAL

PLEASE PRINT

Date _____ (M D Y)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other _____

Name: _____ (last) (first) (initial)

Address: _____ (mailing address) (city) (province) (postal code)

Date of Birth _____ (M D Y) Age _____ Sex _____ Provincial Health No. _____

Occupation / Employer _____ Work Telephone No. _____

Home Telephone No. _____ Cell Telephone No. _____ Email _____

Person responsible for account: ☐ Self ☐ Spouse ☐ Other If other, please complete the following:

Name _____ Telephone No. _____

Address _____ (street) (city) (province)

Family Physician _____ Telephone No. _____

Medical Specialist _____ Telephone No. _____

Do you have dental insurance? ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
NAME OF INSURED	NAME OF INSURED
DATE OF BIRTH (M D Y)	DATE OF BIRTH (M D Y)
EMPLOYER	EMPLOYER
INSURANCE COMPANY	INSURANCE COMPANY
GROUP/POLICY NO.	GROUP/POLICY NO.
DIVISION	DIVISION
I.D. NUMBER OR S.I.N.	I.D. NUMBER OR S.I.N.
CERTIFICATE NO.	CERTIFICATE NO.
DEP. NO.	DEP. NO.
COVERAGE PERCENTAGE	COVERAGE PERCENTAGE
A B C D	A B C D
LIMITS	LIMITS
BASIC MAJOR ORTHO	BASIC MAJOR ORTHO
DEDUCTIBLE ☐ PER PERSON	DEDUCTIBLE ☐ PER PERSON
BASIC MAJOR ☐ PER FAMILY	BASIC MAJOR ☐ PER FAMILY

In case of emergency, please notify: _____ Telephone No. _____

Relationship: _____ Telephone No. _____

Is another member of your family or relative a patient at our office? _____

Whom may we thank for referring you? _____

PLEASE TURN OVER ☛

SPARWOOD
dental clinic

This has been written at the recommendation of the college of Dental Surgeons of British Columbia. Our intent is to clarify our office policies with you to help eliminate misunderstandings. Thank you for your cooperation.

Guarantees

Dentistry is not an exact science; there are many unforeseen variables, thus, planned treatment results are not always attainable, risks may be involved regardless of the expertise of the dentist. We do stand behind our work, and we will make every reasonable effort to be fair. Our goal is to provide quality dentistry for our patients.
We will not be held responsible for unsatisfactory treatment results caused or contributed by a patient's failure to take reasonable care or to follow our advice. If instructions in a given situation are unclear, we encourage you to ask questions.

Patient Responsibility

If you cannot keep your scheduled appointment, please notify the office at least 48 hours in advance. Patients who fail to present themselves for an appointment or fail to cancel 48 hours prior to the scheduled appointment will be considered a "no show" patient and a fee may be applied to their account.

Medical Conditions

It is very important that you notify us of all changes in your health, including conditions, medications used during your course of treatment. Failure to advise us of any changes could result in serious consequences. We ask that you refrain from wearing perfume or other fragrances to the clinic. These odors may trigger asthma, rhinitis or migraines for some of our patients.

Dental Plans & Payments

Co-payments, co-insurance and deductibles are due at the time of your visit. If arrangements need to be made depending on your insurance coverage or if there are special circumstances, please see the front desk to make those arrangements prior to your appointment otherwise a **$25 late payment administration fee will apply.**

For those with dental insurance, it is your responsibility to know the carrier and their exemptions. We contact carriers and the amount quoted for a given procedure is an estimate. Any estimate for insurance is based on the insurance details you have given to us. It is most important to understand this is only an estimate. The amount set by the insurance company may be affected by such factors as annual limits of coverage, non-coverage of certain procedures, etc. We encourage you to become familiar with terms of your dental plan. We will try our best to inform you of any additional fees that may occur, but we remind you that this is, ultimately, your responsibility.

Coverage by your insurance carrier may vary depending on the procedure. We submit forms for insurance claims on your behalf. We will accept direct settlement with the carrier, provided your insurance plan agrees to assign benefits to our dentist; however, if your insurance company is negligent in paying the account, we will then have to bill you for the outstanding amount and notify your insurance company to pay you directly unless other arrangements have been made prior to treatment, by your specific insurance plan -i.e. differences in fees between amalgam (silver) fillings and composite (white) fillings on back teeth, sealants, etc.

I certify that I have read and fully understand the above and agree to comply with these conditions. I also understand that if these conditions are not upheld either I or one of the dentists mentioned above, may choose to end the patient/dentist relationship.

I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary, as this information may be required for my dental care.

CONSENT FOR TREATMENT

I, THE UNDERSIGNED, CONSENT TO THE PERFORMING OF THE DENTAL AND ORAL SURGERY PROCEDURES THAT ARE AGREED BETWEEN MYSELF AND YOUR OFFICE TO BE NECESSARY OR ADVISABLE, INCLUDING THE USE OF LOCAL ANAESTHETIC AS INDICATED, AND WILL ASSUME RESPONSIBILITY FOR FEES ASSOCIATED WITH THESE PROCEDURES AND ANY INTEREST THAT THE BALANCE MAY INCUR. INTEREST RATE 18% PER ANNUM (1.5% PER MONTH).

Patient (Parent, Guardian*) Signature: _____

If Parent or Guardian*, please print name: _____ Date_____

*Guardian of Child or Guardian of Adult under Guardianship