My Dentist @ COLUMBIA SQUARE DENTAL

We at Columbia Square Dental 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: _____

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

Whom may we thank? Name: _____ Relationship: _____

OR □ Newspaper Ad/Mail □ Website (www.mynewwestminsterdentist.com) □ Google Search □ Mobile Bandit

□ 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 ***MINISTRY PATIENTS ONLY***
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)