

Welcome to



(Please fill out both sides.)

Confidential Patient Information

Patient Name: \_\_\_\_\_

Male Female Last First MI Married Single Child Other

Birth Date: (DAY / MONTH / YEAR) \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Names of Children: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_
Mobile \_\_\_\_\_ Email \_\_\_\_\_

Address: \_\_\_\_\_
Street Apartment #
City Province Postal Code

Health Information

Name of Previous Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

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
Mitral Valve Prolapse
Migraine Headaches
Hepatitis
High Blood Pressure
Jaundice
Joint Replacement
Kidney Disease
Liver Disease
Mental Disorders
Nervous Disorders
Pacemaker
Pregnancy
Radiation Treatment
Respiratory Problems
Rheumatic Fever
Rheumatism
Sinus Problems
Smoking
Stomach Problems
Stroke
Thyroid Condition
Tuberculosis
Tumors
Ulcers
Venereal Disease
Codeine Allergy
Penicillin Allergy

Please list your Medications:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

- Have you ever had any complications following dental treatment?
Have been to a hospital or needed emergency care during the past two years?
Are you now under the care of a physician?
Name of Physician: Phone:
Do you have any health problems that need further clarification? :

Is there anything else you would like to add to help us make your visits more comfortable?

Referral Information

Whom may we thank for referring you to our practice?
Google yellowpages.ca Yellow Pages Book Website Other:

## Special Concerns:

Are you nervous about dental treatment?  no  yes \_\_\_\_\_  
Would you like more information on tooth whitening?  no  yes \_\_\_\_\_  
Would you like more information on braces?  no  yes \_\_\_\_\_  
Are you aware of night time tooth grinding?  no  yes \_\_\_\_\_  
Do you require a sports mouth guard?  no  yes \_\_\_\_\_

We provide our patients with the option to participate in our online patient communication system. Some of the features include the ability to: Request Appointments Online  
Confirm Appointments via Email  
Receive Text Message Appointment Reminders  
Submit Patient Satisfaction Surveys  
Refer your friends Online  
You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email or by replying to a text message with "STOP". Standard Text Messaging rates apply.  
Please ensure your email and cell phone #'s are added. We use this information to provide

## Insurance Holder's Information

### Primary Insurance Plans

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: (if different from patient's Address)

\_\_\_\_\_  
Street City Province Postal Code

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

### Secondary Insurance Plans

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Last First MI

Insured's Address: (if different from patient's Address)

\_\_\_\_\_  
Street City Province Postal Code

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name: \_\_\_\_\_

## Please initial all applicable items:

\_\_\_ I authorize release, to my insuring company plan administrator and CDA, the information contained in claims submitted electronically.

\_\_\_ I hereby assign my benefits payable from claims submitted electronically or by mail to Dr. Peter Yao, Dr. Michael Laureola, Dr. Aliea Butt, Dr. Radhika Khorana, Dr. Oren Behar, Dr. Angela Chuang, Dr. David Leung, Dr. John Nikolovski, Dr. Steven Leung and authorize payment directly to him/her.

\_\_\_ 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.

## Financial Policies

Your insurance benefits are between you, your employer and your insurance company. Any benefit difference (deductible, fee guide, ineligible service or co-payment) is your responsibility.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

All estimates for care approximate.

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

\_\_\_\_\_  
Signature of patient, parent, guardian, or guarantor of payments

\_\_\_\_\_  
Printed Name of patient, parent, guardian, or guarantor of payment

Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_