Richmond Centre Dental Clinic
(604) 276-2442 - Phone
(604) 276-2267 - Fax
rcdc1@shaw.ca
https://www.rcdentalclinic.ca/

RICHMOND CENTRE DENTAL CLINIC

Patient Information

Patient Name: _____ ☐Ms. ☐Mr. ☐Mrs. ☐Miss ☐Mstr
Last, First MI (Preferred Name)

Address: _____
Apartment# Street

City: _____ Postal Code: _____ Birth Date: (Date/Month/Year) _____

Email Address: _____ Care Card _____ DL _____

Phone: (Home) _____ Work: _____ Ext _____

Cell: _____ Emergency Contact Name: _____ Phone: _____

Health Information

Date of Last Dental Visit: _____ **Reason for today's visit**: _____

Have you ever had any of the following? **PLEASE CHECK ONLY THOSE APPLY:**

☐AIDS
☐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
☐Hepatitis A B C
☐High Blood Pressure
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Mental Disorders
☐Nervous Disorders
☐Pacemaker
☐**Pregnancy**
☐Due date:_____
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐Tuberculosis
☐Tumors
☐Ulcers
☐Venereal Disease
☐Codeine Allergy
☐Penicillin Allergy

Other Conditions_____

Smoker_____

Medications_____

_____

- 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 past two years? ☐Yes ☐No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐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: _____

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.

_____ Date: _____
Signature of patient, parent or guardian

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Referral Information

Whom may we thank for referring you to our practice? _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐Yes ☐No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insurance Company Name: _____

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Secondary

Name of Insured: _____ Is insured a patient? ☐Yes ☐No

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insurance Company Name: _____

Street City State Zip Code

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Consent for Services

We do NOT do payment plans, so please be advised that payment is expected in full when services are rendered. Our office also requires 48 hour notice for altering any appointment, If this is not given we do apply a fee to your account.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the plan and that he or she is personally responsible for payment of all dental services not covered by your plan. This office will help prepare the patients insurance forms on your behalf and submit to insurance. However, this dental office cannot render services on the assumption that our charges will be paid by your insurance company

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Dentist, or his assignee, at the time said services are rendered. Further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ **Date** _____ **Relationship to Patient**: _____

Signature of patient, parent or guardian