PATIENT INFORMATION

NAME:
Last _____ First _____ Middle _____

Legal name (if different from above): _____

Date of Birth (DD/MM/YY) _____

Address _____

City _____ Prov _____ Postal Code _____

Email _____

Home # _____ Cell # _____ Work # _____ext_____

Occupation _____ Employer _____

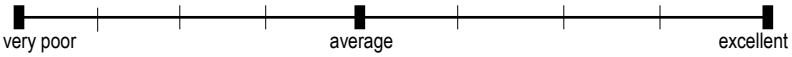
EMERGENCY CONTACT #1
Name _____ Phone #_____

EMERGENCY CONTACT #2 (non-family member)
Name _____ Phone #_____

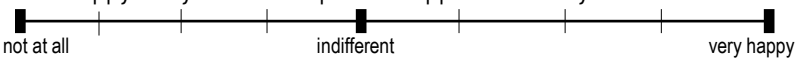
How did you find us? ☐ Family _____ ☐ Friend _____

☐ Website ☐ Other _____

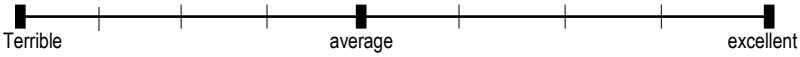
How would **you** describe the present condition of your teeth and gums?



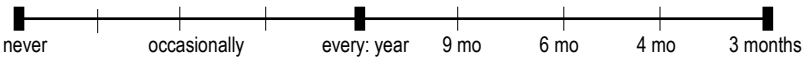
How happy are you with the present appearance of your teeth?



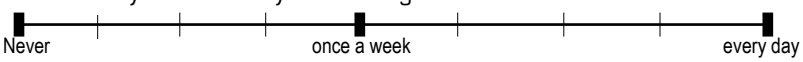
How would you describe your past dental experiences?



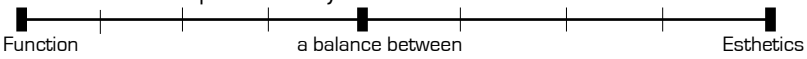
How regularly have you visited the dentist in the past?



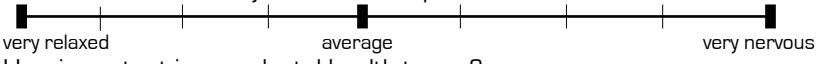
How would you describe your flossing habits?



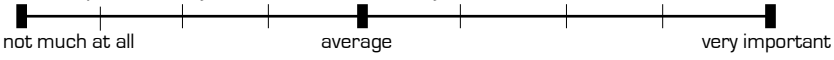
Which is more important for you?



Which best describes you as a dental patient?



How important is your dental health to you?



Do you have any preference for filling material? e.g. Amalgam (silver) vs. Composite (white) vs. other Y N

OFFICE POLICIES

- ✓ Our office tries to be as prompt and on time as possible with all of our patients, therefore appointments booked for you are reserved *just for you.* Because it is extremely difficult to fill appointments missed or cancelled on short notice, we ask that you give us at least **two working days (48 hours) notice** before cancelling any appointment***. A fee may be billed for missed appointments or appointments cancelled without sufficient notice.***
- ✓ In order to serve you more efficiently, payment for services rendered is expected as each day's treatment is completed, unless other financial arrangements have been made prior to commencement of treatment. For some more extensive treatments a deposit of 50% may be required before treatment can begin. For your convenience, we do accept **Interac, Visa,** and **Mastercard**
- ✓ Our fees conform to the fee guidelines published annually by the British Columbia Dental Association. ***Any balance unpaid by a dental insurance company is the responsibility of the client.***
- ✓ It is our desire to be understanding of your financial needs. We are always happy to discuss dental fees and treatment options. If at any time you have a question about treatment recommendations, fees, or services, please do not hesitate to discuss it with us.

PLEASE INITIAL

_____ I authorize diagnosis of my dental health by the use of x-rays, photographs, study models, and other diagnostic tools as deemed necessary.

_____ I authorize Reflections Dental Centre to request X-rays and dental records from my previous dentist(s) as required for the purposes of diagnosis and/or treatment.

_____ I authorize Reflections Dental Centre to request medical information from other health care practitioners as required for the purposes of diagnosis and/or treatment.

_____ I have read and understand the office policies.

FOR INSURANCE POLICY HOLDERS:

_____ I authorize Reflections Dental Centre to file insurance claims directly with my dental insurance company on my behalf, and receive payment directly from them. I understand that this is done as a courtesy on my behalf and agree to pay any balance unpaid by the insurance company.

Patient Name (please print): _____

Guarantor's Name (if different from patient): _____

Signature: _____

Date: _____