PATIENT REGISTRATION FORM

Please take a moment to enter or update your information to help us serve you better. Please print to ensure clarity.

Today's Date_____/_____/_____

_____/_____/_____
Patient Last Name First Name Middle Name

_____/_____/_____
Preferred Name Title (Dr./ Mr./ Ms./ ….) Gender

_____
If child, Parent or Guardian's Name

Birth Date: Month _____ Day _____Year _____
Contact Information:

Mobile Number (_____)_____ Home Number (_____)_____

Work (_____)_____ EMAIL: _____

Address: Street _____ Apartment _____

City _____ Province _____ Postal Code _____

Who may we thank for referring you to our office? _____

Please signal your preferred contact methods:
May we contact you by: ( ) TEXT? ( ) EMAIL? ( ) CALL?

DENTAL INSURANCE

Do you have Dental Insurance Coverage?	☐ YES	☐ NO
Are you covered by more than one Dental Insurance Plan?	☐ YES	☐ NO
Are you covered by a Student Insurance Plan?	☐ YES	☐ NO

If yes, which university or college Dental insurance Plan? _____
Are you covered by a governmental benefit plan? ☐ YES ☐ NO

If yes, which plan? _____

PRIMARY DENTAL INSURANCE
Please ensure that the information included below corresponds exactly to the information on your insurance card.

_____/_____/_____
Last Name of Insured First Name Middle Name

Insured's Birth Date: Month _____ Day _____Year _____
ID (or Member or Certificate) Number: _____
Group (or Plan) Number: _____
Division Number (if any): _____
Insured's Address: Street _____Apartment_____

City _____ Province _____ Postal Code_____

(Please complete side 2)

Side 2 _____

SECONDARY INSURANCE

Complete when patient has coverage by more than one insurance policy. Please ensure that the information included corresponds exactly to the information on the insurance card.

_____/_____/_____

Last Name of Insured First Name Middle Name

Insured's Birth Date: Month _____ Day _____Year _____

ID (or Member or Certificate) Number: _____

Group (or Plan) Number: _____

Division Number (if any): _____

Insured's Address: Street _____ Apartment. _____

City _____ Province _____ Postal Code_____

OFFICE POLICIES AND PROCEDURES

PRIVACY: All personal information provided to us by a patient is treated as confidential information. No one is given unauthorized access to your personal information.

Patient information is collected to deliver safe and efficient patient care, to assess your health needs, to advise you of treatment options, to offer and provide treatment, care and services in relation to the oral and maxillofacial complex and dental care generally, and to allow us to efficiently provide follow up treatment. Our office also uses information to schedule and confirm appointments and distribute health care information.

Patient information may be provided to other health care providers, including dentists and specialists who are either referred from or referred to dentists and to comply with legal and regulatory requirements of the Royal College of Dental Surgeons and the Regulated Health Professionals Act. Patient information may also be provided to your insurance provider to complete dental claims presented to your insurance provider, to process and collect payment of accounts, and to comply with audit procedures that may be needed to comply with audit procedures that may be needed to comply with legal and businesses requirements.

MISSED APPOINTMENTS AND LATE CANCELLATIONS: The appointment date and time scheduled for a Patient at our practice is reserved exclusively for you. We do our best to keep on schedule and to keep wait time to a minimum. To make this possible, we ask that you be on time for your appointment. As a courtesy to our Patients we do not "double book" appointments. For this reason, you may be charged for missed appointments and late cancelations without good reason.

FEES AND INSURANCE COVERAGE

Patients are responsible for the cost of their treatment. Unless otherwise agreed, payment is generally made at the time that the service is provided. The fees charged in this office are those contained in the Fee Guide of the Canadian Dental Association.

Following your treatment, our staff submits an Insurance Claim on your behalf to your insurance company electronically using the CDA Net. You can expect to receive payment from your insurance company within 3 to 5 business days following your treatment. I understand that regardless of insurance claims that I am ultimately responsible for and agree to pay any outstanding balance for services provided.

Authorization for Electronic Submission of Claims: I hereby authorize the release, to my dental plan's administrator and the CDA of information contained in claims and predetermination of insurance submitted electronically. I also authorize the communication relating to the coverage of services described to Dr. Aveen Hassan. This authorization continues until the undersigned revokes the same.

I acknowledge that I have read and understand the Policies and Procedures set out above and hereby agree to them.

Patient's Signature: _____ **Date:** _____

Intake staff Name: _____