



**VANCOUVER
CENTRE**
DENTAL CLINIC

Dr Mark K. Suyama Inc

Tel: (604) 682-1601

Unit 1B11, Vancouver Centre Mall
650 West Georgia Street P.O. Box 11520 Vancouver, B.C. V6B 4N7

Name Last: _____ Name First: _____ Usually Called: _____

Address: _____ City: _____ Postal Code: _____

Telephone Home: _____ Business: _____ Local/Ext: _____

Birthdate Day: ___ Month: ___ Year: ___ Social Insurance Number: _____

Occupation: _____ Employer: _____

How did you find out about our office?

Phone Book: ___ Sign: ___ Web: ___ Referred: ___ Other: _____

If referred, whom may we thank? _____

We would be happy to bill your insurance company directly for their portion of your dental treatment, provided we have the following information. PLEASE NOTE THAT THE POLICY IS BETWEEN YOU AND YOUR INSURANCE COMPANY, AND THAT YOU WILL BE RESPONSIBLE FOR PAYMENT OF ANY ACCOUNTS NOT PAID. YOU ARE ALSO RESPONSIBLE FOR YOUR PERCENTAGE OR DEDUCTIBLE AT THE TIME OF YOUR APPOINTMENT.

Name of Insurance Company: _____ Insureds' Name: _____

Policy Holder (Employer): _____ Insureds' Birthday Day: ___ Month: ___ Year: ___

Group Policy/Plan No: _____ ACC/DIV(if applicable): _____

Insured's Certificate ID No: _____ Deductible: _____ Limits: _____

Coverage: A (Basic): ___% B (Dentures)___% C (Crown & Bridge) ___% D (Ortho): ___%

Dependent Number: _____ Do your claim forms go to your employer? : _____

How do you wish to pay for your dental services?

Cash ___ Debit Card ___ Visa ___ Mastercard ___ American Express

Payment is due at the time of the appointment unless other arrangements have been made.

Dental History

How long since your last dental visit? _____

Have you ever had a bad reaction to a dental anaesthetic? _____

Are you presently wearing partial dentures or full dentures? _____

If yes, how old are they? _____

What is your present complaint (if any)? _____

The data on this confidential questionnaire is essential to render the best professional care. We appreciate your cooperation on filling it out carefully so that we will have accurate records.

Medical History

Family Physician: _____ Phone Number: _____

Are you presently under the care of a physician? ___

If yes, please explain _____

Have you had a medical examination in the last year? _____

Have you ever been hospitalized or had surgery? _____

If yes, please explain _____

Do you use medicine now? (Please list) _____

Have you ever had any of the following diseases? (please circle)

Hepatitis Jaundice Diabetes High or Low Blood Pressure Tuberculosis Any lung disease Venereal disease
Hart attack Heart murmur or heart disease Stroke Epilepsy Cancer Kidney disease Mental or nervous disease
Arthritis Rheumatic fever Stomach problems Allergies AIDS None of the above

Have you ever experienced any unusual reaction to any of the following drugs? (please circle)

Aspirin Penicillin Codeine Iodine Sulfonamide(sulpha) Barbituates (sleeping pills) Local anaesthesia or other medicine None of the above

Do you bruise easily or bleed abnormally? ___

Do you have any prosthetic implants or joints? i.e. knee, hip, _____

Are you HIV POSITIVE? ___ Have you ever been tested? _____

Have you ever had any injury, surgery or X-ray therapy to your face or jaws? _____

If yes, please explain _____

Do you have any disease, condition or problem not listed above that you think the doctor should know about

WOMEN ONLY! Are you pregnant? ___ If yes, due date _____

Do you take birth control medication? _____

DUE TO THE PRECISE NATURE OF APPOINTMENT SCHEDULING, THERE WILL BE A 40\$ CHARGE FOR APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE!

I, THE UNDERSIGNED (PATIENT OR LEGALLY RESPONSIBLE PARTY) AUTHORIZE DENTAL TREATMENT TO BE RENDERED BY THE DENTIST AND HIS STAFF, AND ASSUME FINANCIAL RESPONSIBILITY

X _____ X _____
date signature