Patient name: ____

We are working towards updating our system.
In the future, would you like to receive email or text reminders for your appointments?
(Please leave this area blank if you do not want to receive appointment reminders via text or email.)

Email: ____ Cellphone number: ________________________________

*Please let us know what your preferred contact method is.

Consent Regarding Dental Benefits

I authorize release, to my dental benefits plan administrator and the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to Dr. Eugene Tang. This authorization shall continue in effect until the undersigned revokes the same.

I hereby assign my benefits, payable from claims submitted electronically, to Dr. Eugene Tang. and authorize payment directly to him/her. This authorization shall continue in effect until the undersigned revokes the same.

Please note: We strongly recommend you check with your insurance provider with regard to benefit limits and frequency of treatment (e.g. exams, dental hygiene, etc.). Due to the Protection of Privacy Act, insurance providers no longer supply the details of patient plans to dental providers.

All fees not covered by the benefits plan are the responsibility of the patient.

Signature of patient, parent or guardian: ________________________________ Date: ________________

Cancellation Policy

Your dental appointment is considered confirmed at the time of booking. We will do our best to contact you with a courtesy reminder, however, it remains your responsibility to make sure that you arrive for your appointment on time.
We are happy to change or cancel your appointment if you provide us with a minimum of 24 hours notice. This notice allows other patients the opportunity to reserve this time.
If you provide us with less than 24 hours notice or if you do not show up to your scheduled appointment, we reserve the right to charge a missed appointment fee as set out by the BC Dental Association. In extenuating circumstances, the fee may be waived.

In the event there is a pattern of missed appointments, we will assess the history and a decision will be made on how we will proceed with potential future appointments.

Note: Insurance companies **do not cover** fees for missed appointments, therefore all missed appointment fees are the responsibility of the patient.

Signature: ____________________________________ Date: ___________________

Patient Medical Information

First Name ____________________________________ Last Name ____________________________________

(If applicable) Health Card # ________________________ Status # _________________________

Date of birth ____________________________ (MM/DD/YYYY) Address _____________________________________

City ________________________________ Postal Code _____________________________

Phone Cell ___________________________ Text reminder **Y N** Home ___________________________

Email: ____ Email reminder **Y N**

Insurance Company _________________________ Policy Holder Name & DOB _________________________________

Group /Policy # ____________________________ Certificate/Subscriber ID # _____________________________

Are you being treated for any medical conditions at the present time or have been treated within the last year? **Y N**

If yes, explain: _______________________________________ When was your last medical checkup: _________________

Have there been any changes in your general health in the last year? **Y N**
If yes explain:
____

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? **Y N**
If yes, please list:
____
____

Do you have any allergies? **Y N**
If you answered yes, please list using the categories below:
Medications ____

Latex/Rubber Yes No Other (eg hayfever, foods) ____

Have you ever had any uncommon or adverse reactions to any medicines or injections? **Y N**
If yes, explain: ____

Do you have or have you ever had asthma? **Y N**

Do you have or have you ever had any heart or blood pressure problems? **Y N**

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease), or a heart transplant? **Y N**

Have you ever had hepatitis, jaundice, or liver disease? **Y N**
Type of hepatitis: ________________________

Do you have a prosthetic or artificial joint? **Y N**
If yes, explain: ____

Do you have a bleeding problem or bleeding disorder? **Y N**
If yes, explain: ____

Have you ever been hospitalized for any illness or operation? **Y N**

If yes, explain: ____

Do you have any conditions or therapies that could affect your immune system, e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy? **Y N**

Do you have or have you ever had any of the following (CIRCLE):

AIDS	Digestive Disorders /Acid Reflux	Hypo/Hyperglycemia	Sexually Transmitted Infection
Alzheimers	Drug/Alcohol Dependency	Kidney Disease	Shortness of Breath
Angina	Emphysema	Lung Disease	Sleep Apnea
Anemia	Epilepsy or Seizures	Lupus	Steroid Therapy
Arthritis	Fibromyalgia	Migraine	Stomach Ulcers
Blood Transfusion	Head/Neck Injury	Mitral Valve Prolapse	Stroke
Cancer	Heart Attack	Osteoporosis Medications (e.g. Fosamax, Actonel)	Thrush
Chest Pain	Heart Murmur	Pacemaker	Thyroid Disorder
Cold Sores	High/Low Blood Pressure	Parkinsons Disease	TMJ Disorder
Diabetes Type 1	HIV	Radiation/Chemotherapy	Tuberculosis
Diabetes Type 2	Hodgkins Disease	Rheumatic Fever	

Are there any conditions above not listed that you have or have had? **Y N**
If yes, please list: ____

Are there any diseases or medical problems that run in your family? (e.g. diabetes, cancer, or heart disease) **Y N**
If yes, explain: ____

Do you smoke or chew tobacco products? **Y N**

Are you nervous during dental treatment? **Y N**
If yes, please explain: ____

Are you pregnant? **Y N**