DR. AMARJOT S. SAJAN, INC

Welcome to our clinic! It is our optimal goal to provide you and your family with the highest quality of dental care, while maintaining a friendly and relaxing environment. To keep our standard of care to a level which best serves your dental needs, we ask you to please observe the following guidelines:

**Appointments**
Our office is open extended hours for the convenience of our patients, and in consideration of their work schedules and children's school responsibilities. By being open Monday/Tuesday from 9:00am to 5:00pm and Wednesday/Thursday from 8:00am to 4:00pm we can meet your dental health care needs at a time that is convenient for you.

**Cancellation Policy**
There are many times when our patients require urgent or emergency treatment and therefore need an appointment as soon as possible. When patients give the clinic advanced notice to reschedule or cancel an appointment, this time can in turn, be allocated to these patients in need of immediate care. This way, the clinic can best serve the needs of ALL patients.

Our practice policy is that patients wishing to change their commitment to a scheduled appointment must give the office a minimum of 48 hours notice. **If less than 24 hours notice is given to change an appointment, a fee of $30 / 30 minutes of appointment time will be assessed. In the event that no notice is given and the patient does not show up for their scheduled appointment, a fee of $50 / 30 minutes of appointment time will be assessed.** Please note that insurance companies do not cover fees for broken appointments, therefore payment is the patient's responsibility.

*** Exceptions will be made on a case by case basis.**

In the event a patient does not "show up" without a valid reason on multiple occasions, our policy is to ask the patient to find a different practice, at which point our administrative staff will be happy to transfer the records of that patient to a new clinic.

**Payment Policy**
Unless prior arrangements have been made with administration, payment is due upon completion of treatment. Please note that not all services may be covered by your insurance carrier and every insurance plan has its own unique "quirks" and exceptions. It is the patient's responsibility to cover procedures that are not covered by their insurance plan. All overdue accounts are subject to a monthly interest fee of 1.50% and yearly interest fee of 18%.

We at Dr Amarjot S Sajan's Dental Clinic look forward to taking care of your oral health needs and welcome you and your family to our team of dental professionals.

**The following section is to be completed by the patient.**

I have read the above policies of Dr Amarjot S Sajan's Dental Clinic and understand my responsibilities as a patient.

_____ _____

Date Signature of patient

# PATIENT CONSENT FOR TREATMENT FILLING MATERIALS

I understand that Dr. Sajan does not use silver-mercury alloy materials to fill/restore cavities in this office. I understand that I will have tooth coloured composite resin materials used to fill/restore my cavities. I understand that in the event that I have insurance coverage, that my insurance may only pay for the equivalent cost of silver-mercury fillings, and that I would therefore be responsible for the shortfall of my insurance coverage. I will inform Dr Sajan and/or his staff if and when I wish to have gold used to fill/restore my cavities. I understand that in the event that I have insurance coverage, that my insurance may only pay for the equivalent cost of silver-mercury fillings, and that I would therefore be responsible for the shortfall of my insurance coverage.

_____ _____

Date Signature of patient

# PATIENT CONSENT FOR COLLECTION OF INFORMATION

I hereby authorize Dr Amarjot S Sajan Inc to collect and use my personal information, including:

- Name, Age, Birthdate
- Address
- Contact Information (Email Address(es), Phone Number(s) etc)
- Medical and Dental History
- Insurance Information
- Payment Information

To use for:

- Providing dental care
- Contacting the patient about appointments, bills and information about the practice
- Providing information to other dentists and specialists
- Providing information to other health care providers (physicians, pharmacists, etc).
- Billing
- Any audits required by the College of Dental Surgeons of BC, the BC Dental Association, insurance providers or practice auditing firms

_____ _____

Date Signature of patient

# Medical and Dental Questionnaire - New Patient Form

| | | |
|---|---|---|
| Last Name: | Given Names: | Date of Birth: |
| Name of Person Completing Form: | | Relationship to Patient: |
| How did you hear about our clinic? | | |
| Mailing Address: | Email Address: | |
| City and Province: | | Postal Code: |
| Home Phone #: | Business Phone #: | Cell Phone #: |
| Name of Emergency Contact: | Emergency Phone #: | Relationship to Patient: |
| Preferred Method of Contact:(Circle)<br>Email Home Phone Business Phone Mail Cell Phone | | |

**Dental Questions:**

Have you had regular dental care in a past? Yes No

Name of Dentist _____ Dentist Phone # _____

What was the date & purpose of your last dental visit? _____

How often did your previous dentist recommend you receive hygiene treatment? _____

Have you ever seen a dental specialist? Yes No

If Yes, what was the procedure?_____

Name of Dentist _____ Dentist Phone #_____

Do you have any of the follow oral habits (Circle):

Clenching Grinding Ice chewing Nail Biting

Have you ever received oral care instruction? Yes No

How often do you brush your teeth? _____ How often do you floss? _____

Are you satisfied with the function and appearance of your teeth? Yes No

Have you ever had a negative experience at the dentist? Yes No

If Yes, please explain:_____

_____

Have you ever been told to take prophylactic antibiotics before dental treatment? Yes No

Have you ever had any reactions or problems with anaesthetic or dental work? Yes No

If Yes, please explain _____

What is your main dental concern?_____

What Is Your Goal (Circle):

Optimal oral health Optimal esthetics Pain/disease free oral cavity

Although dental personnel primarily treat the area in and around your mouth, your mouth is a gateway to your entire body. Health problems that you may have, or medication that you may take could have an important interrelationship with the dental care you will receive. **If any of the following apply to you, please check them off:**

## Health Questions:

| | | | |
|---|---|---|---|
| **Rheumatic Fever** | | **Congenital Heart Condition** | |
| **Heart Murmur** | | **Infective Endocarditis** | |
| **Stroke or Heart Attack** | | **Joint Replacement** | |
| *If Yes, when?*<br>*What is your INR?* | | *If Yes, when?*<br>*What joint?* | |
| **Blood Pressure Issues** | | **Heart Issues** | |
| *High or Low Blood Pressure?*<br><br>*Is it under control?* | | *If Yes, what issues?*<br><br>*Is it under control?* | |
| ***Kidney Issues*** | | **Lung/Breathing Issues** | |
| *If Yes, what issues?*<br>*Is it under control?* | | *If Yes, what issues?*<br>*Is it under control?* | |
| **Stomach / Digestive Issues** | | **Diabetes** | |
| *If Yes, what issues?*<br>*Is it under control?* | | *If Yes, what type?*<br>*Is it under control?* | |
| **Blood Disorders** | | *What was your last reading?* | |
| *If Yes, what disorder?*<br>*Is it under control?* | | *How often do you check?* | |
| **Sinus Issues** | | **Pacemaker/Artificial Valves** | |
| *If Yes, what issues?* | | *If Yes, when was it placed?* | |
| **Psychological/Stress Disorder?** | | **Epilepsy/History of Seizures** | |
| *If Yes, what disorder?*<br>*Is it under control?* | | *If Yes, how often do you have seizures?*<br>*Is it under control?* | |
| **Communicable Disease (AIDS, Hep C, etc)** | | **Thyroid Issues** | |
| *If Yes, what disorder?*<br>*Is it under control?* | | *If Yes, what issues?*<br>*Is it under control?* | |
| **Abnormal Tumors or Growths** | | **Women:** Are you, or could you be, pregnant? | |

Is there any other health issue that we should be aware of?_____

Have you been examined or treated by a medical doctor in the last year? Yes No
If Yes, Reason for Seeking Medical Attention: _____
Name of Medical Doctor:_____ Doctor's Phone #:_____

Have you ever been seriously ill or hospitalized? Yes No
If Yes, please explain:_____
Have you ever experienced abnormal bleeding associated with a previous surgery or trauma? Yes No

Are you currently taking any medication, herbal remedies or non-prescription drugs? Yes No
If Yes, please list (with dosage): _____
_____

Do you, or have you been told that you, snore? Yes No
Do You Smoke or Use Chewing Tobacco? Yes No If Yes, how much/how often?_____
Do you have any allergies? Yes No If Yes, do you carry an Epi-pen? Yes No
Please list allergies: _____
_____

**Patient or Guardian Signature**_____ **Date** _____