SAIDI DENTAL GROUP
Dr. S. Masoud Saidi Inc.
#201, 6351 197th Street
Langley, BC V2Y 1X8
604-539-9374

PLEASE PRINT

PATIENT FORM

ADULT PATIENT (OR PARENT OR GUARDIAN)

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ ○ Male ○ Female
DD / MM / YYYY

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Address: _____

City: _____ Province: _____ P/C: _____

Mailing Address (if different): _____

City: _____ Province: _____ P/C: _____

E-mail Address _____
(For use of appointment notification, office updates or newsletters)

Legal Resident of (Country): _____

Occupation: _____

Employer: _____

Business Address: _____

City: _____ Province: _____ P/C: _____

CHILD PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ ○ Male ○ Female
DD / MM / YYYY

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

School: _____ Contact Person & Relation: _____

If Address of Residence is Different Please Complete:

Address: _____

City: _____ Province: _____ P/C: _____

E-mail Address _____

Legal Resident of (Country): _____

GETTING TO KNOW YOU

Who may we thank for referring you?

Is there someone you know who comes to our office?

Emergency Contact: Relation:

Home Phone #: Cell Phone #: Work Phone #:

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (if different from previous)

Name: Relationship to Patient:

Home Phone #: Cell Phone #: Work Phone #:

Address:

City: Province: P/C:

E-mail Address

Employer:

DENTAL INSURANCE PRIMARY CARRIER

Insurance Company: Policy # ID or Certificate #

Policy Holder: DOB:
DD / MM / YYYY

Plan Coverage: Basic % Major % Ortho %

Yearly Deductible $ Yearly Limit (Basic) $ (Major) $ (Combined) $

Scaling and Root Planning Units per year Recall Frequency Months or 2 x Calendar

DENTAL INSURANCE SECONDARY CARRIER

Insurance Company: Policy # ID or Certificate #

Policy Holder: DOB:
DD / MM / YYYY

Relationship to Patient:

Plan Coverage: Basic % Major % Ortho %

Yearly Deductible $ Yearly Limit (Basic) $ (Major) $ (Combined) $

Scaling and Root Planning Units per year Recall Frequency Months or 2 x Calendar

Please Initial Each Paragraph after Reading

1. I hereby authorize Doctor S. Masoud Saidi and Dr. S. Masoud Saidi Inc. and or any one employed by this organization to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of

   [ ]'s dental needs.

   [ ]

2. Upon such diagnosis, I authorize completion of all recommended treatment by Dr. S. Masoud Saidi Inc. and its employees, **that is mutually agreed upon by me** and to employ such assistance as required to provide proper care. If I am sedated for my treatment or should I not be available at the time of my dependant's treatment, I also authorize any further treatment that may be diagnosed interoperatively and that the Doctor deems appropriate but that may have not been discussed (previously).

   [ ]

3. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using anesthetic agents and generally dental/oral treatment embodies certain risks. **I understand that I can ask for an explanation of any possible complications**.

   [ ]

4. Two business day notice for appointments under one hour and four business day notice for appointments over 2 hours is required for changing your appointment. Otherwise, a fee will be charged according to the amount of time booked for your reserved appointment.

   [ ]

5. Dental plans vary greatly. **The forms conditions and percentages of payments are contracted between you, your employer and the insurance company**. The percentages of coverage relate to Insurance Company Fee Schedules, which may not necessarily correspond to the College of Dental Surgeons of B.C. fee schedule. If your dental plan does not cover 100% of the costs of your dental treatment, you are required to pay any outstanding balance. It is your responsibility to determine what percentages of proposed treatment is covered by your dental plan. **In order to assist you with this process, we routinely predetermine new and major treatment for our patients**.

   [ ]

6. I understand that Dr. S. Masoud Saidi Inc. is not responsible for collection of my benefit payments from my dental insurance provider.

   [ ]

7. I will make Dr. S. Masoud Saidi Inc. aware of any limitations in my dental benefit that I deem necessary, prior to each of my appointment date.

   [ ]

8. I understand that my dental insurance may not provide benefit for part or all of certain procedures. I will take it upon myself to check for these limitations prior to any treatment.

   [ ]

9. Keeping within dental insurance limits of any kind (yearly, frequency, intervals) will be my responsibility and prior to each of my visits I will check to make sure that I am satisfied with the amount of coverage that I will receive for that appointment.

   [ ]

10. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1⁄2% (18%APR) may be added to my account.

    [ ]

We value our relationship with you and would like to send you information electronically relating to Saidi Dental Group. In order to do this, we are collecting your consent to receive electronic messages from us in the form of appointment reminders, newsletters, upcoming events and other clinic information. Please take a moment to select either "OPT IN" or "OPT OUT". Opting in will provide Saidi Dental Group consent to communicate with you electronically. Opting out will indicate that you do not wish to receive any electronic communication from us.

OPT IN [ ] OPT OUT [ ]

Signature: _____ Date: [ ]

Patient / Patient Guardian

DD / MM / YYYY

PLEASE PRINT OUT THIS FORM ONCE COMPLETED OR YOU CAN SUBMIT TO US ELECTRONICALLY

SUBMIT NOW