

Scott Yamaoka, DDS, MS, FRCD(c)



Suite 350 - 2425 Oak Street, Vancouver, BC Canada V6H 3S7
604-738-3626 Fax 604-738-7275
Email: drscottymaoka@shawbiz.ca
www.healthysmilevancouver.com

CONFIDENTIAL PERSONAL INFORMATION

Mr. ____ Ms. ____ Mrs. ____ Dr. ____ Other: ____

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

Address: _____ City: _____ Postal Code: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date ____ Day/____ Mo/____ Yr E-mail Address: _____

Dentist: _____ Phone: _____

Current Physician: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone Number: _____

INSURANCE INFORMATION

Primary Insurance

Insurance Name _____

Group # _____ ID # _____

Subscriber Name _____

Date of Birth _____

Relationship to Patient _____

Secondary Insurance

Insurance Name _____

Group # _____ ID # _____

Subscriber Name _____

Date of Birth _____

Relationship to Patient _____

Dr. Yamaoka and his team make every effort to accommodate you and your schedule. If you need to reschedule or cancel your appointment, we require notification of 2 of our business days for regular appointments and 14 of our business days for surgeries. Please note that our office is open on the occasional Fridays. We reserve the right to charge your account for appointments missed or cancelled without appropriate notice. **Please Initial** _____

NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE. I, the undersigned, certify that all of the medical and dental information provided is true to the best of my knowledge, and I have not knowingly omitted any information. I also consent to my physician being contacted if necessary to obtain information that is required for my dental care. **Please Initial** _____

Signature _____ **Date** _____