NEW PATIENT REGISTRATION

Patient Information

Last Name: _____ First Name: _____ M.I. _____

Name I go by: _____ Salutation: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other: _____

Sex: ☐ Male ☐ Female Age: _____ Date of Birth: _____ /_____ /_____

BC Med #: _____

Contact Information

Street Address: _____ Apt: _____

City: _____ Province: _____ Postal Code: _____

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

I prefer to be called: ☐ At home ☐ At work ☐ On my cell

Email Address: _____

Emergency Contact

Person to notify in case of EMERGENCY: _____

Relationship: _____ Phone: _____

Payment Information

Responsible Party: _____ Relationship to patient: _____

Street Address *(if different than above):* _____

City: _____ Province: _____ Postal Code: _____

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

Insurance Information

Please provide the information for the person that is the **Primary Card Holder (Subscriber)** for your insurance.

Name of Insurance Company: _____ (*Copy of card required)*

Subscriber / Policy I.D.: _____ Group #: _____

Last Name: _____ First Name: _____ M.I. _____

Street Address: _____ Apt: _____

City: _____ Province: _____ Postal Code: _____

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

Employer: _____

Date of Birth: _____ /_____ /_____ Primary card holder relationship to patient: _____

Privacy Directives

The office of Dr. Rolf Maijer is committed to protecting your privacy. We will only communicate with those individuals that you choose to list on this form.

Please answer the following:

May we discuss your appointments and/or treatment with your spouse or significant other? ☐ Yes ☐ No

Is there anyone else that you authorize to discuss your appointments/treatment with us? ☐ Yes ☐ No

Name, Relationship: _____

Name, Relationship: _____

Consent to Coordinated Care

Dr. Maijer would like to communicate with your doctors about your condition and your treatment progress in order to achieve the best outcomes possible. Please provide the names and contact information for your health care team below:

Family Doctor

Name

Phone Fax

Address

Family Dentist

Name

Phone Fax

Address

Other Doctors / Specialists

Name

Phone Fax

Address

Conditions Treated

Name

Phone Fax

Address

Conditions Treated

Release of Information

If you would like us to send a copy of your medical information (i.e. exam findings, diagnosis, treatment programs, etc.) to any other party, please sign below. (Note: This is optional.)

By signing below, I authorize Dr. Maijer to release my medical information to (check all that apply):

- ☐ *The clinician(s) that referred me to Dr. Maijer for evaluation and/or treatment.*
- ☐ *My primary care physician, dentist, and/or other health care providers listed above.*
- ☐ *Insurance companies or other organizations or entities as may be required by said representatives for payment of claims for services provided by Dr. Maijer.*
- ☐ *Representatives of local, provincial or federal agencies (If required by law).*

Patient Signature _____ Date _____

Dr. Rolf Maijer, inc
4464 West Saanich Road • Victoria, BC • V8Z 3E9 • p: 250-800-5252 • f: 855-266-0505

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Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____, authorize _____ to disclose
(Print your name) *(Print name of health information custodian)*

my personal health information consisting of:

Medical records, including sleep intake, study reports and clinician notes

TO:

Dr. Rolf Maijer
4464 West Saanich Road
Victoria, BC V8Z 3E9

Phone: (250) 800-2552

Fax: (855) 266-0505

I understand the purpose for disclosing this personal health information to the dental sleep medicine and pain management practice noted above. I understand that I can refuse to sign this consent form.

Patient Name: _____ Phone: _____

Signature: _____ Date: _____

Witness Name: _____ Phone: _____

Signature: _____ Date: _____

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