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Certified Specialist in Pediatric Dentistry

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Certificate in Pediatric Dentistry



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Patient Information

How did you hear about us?: _____

Patient Name: _____ DOB: _____

Home Address: _____ City: _____ Phone #: _____

Fathers Name: _____ DOB: _____ Cell #: _____ Email: _____

Mothers Name: _____ DOB: _____ Cell #: _____ Email: _____

In case of an emergency and a parent cannot be reached, please contact:

Name: _____ Relation: _____ Cell #: _____

Patient Insurance Information

Primary Coverage:

Policy Holder: _____ Birthdate: _____ Name of Employer: _____

Name of Plan: _____ Group or Policy: _____ ID/SIN: _____

Division: _____ Certificate: _____ Verification Required by Employer: () Yes () No

Fee Schedule: _____ Percentage: A: Basic () B: Major () C: Ortho ()

Deductible: _____ Limit: _____ S.F. () Yes () No

Secondary Coverage:

Policy Holder: _____ Birthdate: _____ Name of Employer: _____

Name of Plan: _____ Group or Policy: _____ ID/SIN: _____

Division: _____ Certificate: _____ Verification Required by Employer: () Yes () No

Fee Schedule: _____ Percentage: A: Basic () B: Major () C: Ortho ()

Deductible: _____ Limit: _____ S.F. () Yes () No

As a courtesy service, our office will accept payment from all dental plans. Any portion that your dental plan does not cover is the responsibility of the plan holder, and is due when services are rendered.

Date: _____ **Signature:** _____