WELCOME !

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us to meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

Patient Information (confidential):

Full name:____________________________ Date of birth ________________ Patient No.____________________

Home Address:________________________ City ________________________ Today's date:__________________

Email________________________________ Cell No.: __________________ Sex: ☐ F ☐ M

Do you prefer to receive calls at your?: ☐ Home ☐ Work ☐ Cell Phone Home tel.: ____________________

Work tel.:_____________________

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widow

If student, Name of School/College: _______________ City____________________ Full/t ☐ Part/t ☐

Patient or Patient/Guardian's Employer: ____ Work phone.: __________________

Business address:____ City_____________________________

Spouse or Patient/Guardian's name: ____________________ Employer __________________ Work Phone.: __________________

Whom may we thank for referring you? ____

Person to contact in case of emergency:____ Phone.: ___________________________

Responsible Party:

Name of person responsible for this account:_______________________________________ Relationship to Patient _______________

Address: ____ Home Phone: ______________________

Email:____CellPhone: _________________________

Date of birth: ____ Financial Institution: ____________________________

Employer _____________________________________ Work Phone: _____________________

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment is expected in full at each appointment.

☐ Cash ☐ Credit card ☐ VIZA ☐ Master card ☐ I wish to discuss the office's payment policy

Insurance Information

Name of insured: ____ Relationship to patient_____________________

Date of birth: __________________________ Date Employed ____________________________________

Name of Employer: ____ Work Phone: ______________________________

Address of Employer: ________________________________ City _____________________________________

Insurance company: ___________________________________ Group No.: ______________________ Policy/ID:____________

Address: ____ City___________________________

How much have you used?___________________________ Max. annual benefit _________________________________

Do you have any additional insurance? ☐ **Yes** ☐ **No** **If yes, complete the following:**

Name of insured: ____ Relationship to patient_____________________

Date of birth: ____ Date Employed___________________________________

Name of Employer: ___________________________________Union or Local No.___________Work Phone.: ________________

Address of Employer: ________________________________City ________________________ Province ____________________

Insurance company: ___________________________________ Group No.: _______________________ Policy/ID:____________

Address: _____________________________________ City___________________________ Province: _______________________

How much is your deductible?_______________ How much have you used?_________________ Max. annual benefit ___________

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