Welcome!

Thank you for choosing our dental healthcare team!

Please fill out this form as completely as possible. All information will be kept confidential and will not be released without your written consent. If you have any questions or need assistance please ask us – we will be glad to help.

Patient Information

Check appropriate box: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Master ☐ Dr.

Name _____ Birth date ____/____/____ ☎ Home _____
First name Last name Month Day Year

Address _____ City _____ Province _____ ☎ Work _____

Postal code _____ Email _____ ☎ Cell _____

Person to contact in case of emergency _____ ☎ Emerg _____

Whom may we thank for referring you? _____

Insurance Information

Name of policy holder _____ Relationship to patient _____

Policy holder: SIN # _____ Birth date ____/____/____ ☎ Work _____
Month Day Year

Name & address of employer _____

Insurance company _____ Group # _____ ID # _____

Insurance coverage: Deductible _____ Annual limit _____ Basic _____ % Major _____ % Ortho _____ %

Do you have additional insurance? ☐ Yes ☐ No If yes, name of policy holder _____

Name & address of employer _____

Insurance company _____ Group # _____ ID # _____

Insurance coverage: Deductible _____ Annual limit _____ Basic _____ % Major _____ % Ortho _____ %

Responsible party

Person responsible for this account: ☐ Patient ☐ Other

Address & Phone (if different from patient's): _____

Payment

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

☐ Cash ☐ Debit card ☐ Personal cheque, driver's license # _____

☐ Visa ☐ MasterCard _____

Note: We are more than happy to bill your insurance plan directly for services performed but we are not responsible for charges not covered by your plan. Fees charged are based on the current year's dental fees schedule and amounts not covered by your insurance due to any limitations or exclusions in coverage are the direct responsibility of the patient, parent or guardian of the account. Thank you.

I hereby authorize the dentist to perform dental procedures as may be necessary for me or for my dependents, including the use of local anesthetic, and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient's or guardian's signature _____ Date _____