Welcome

Patient ID# _____

Medical Alert _____

In an effort to serve you better, we would ask that you complete the following. We will be glad to assist you. PLEASE PRINT.

Patient Information

A parent or guardian will be responsible for decisions on my treatment ☐ Yes ☐ No

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: ____/____/____ Home Tel. (____) _____ Work Tel. (____) _____
D M Y

Emergency Contact: _____ Tel. (____) _____

Family Doctor: _____ Tel. (____) _____

Referring Doctor: _____ Tel. (____) _____

Financial Information

Method of payment: Cash ☐ Cheque ☐ Credit Card ☐ Insurance ☐ Other ☐

Person responsible for financial matters: Self ☐ Spouse ☐ Parent/Guardian ☐ Other ☐

IF DIFFERENT FROM ABOVE

Name: _____
First Initial Last

Address: _____
Street Apt. City Prov. Postal Code

Date of Birth: ____/____/____ Home Tel. (____) _____ Work Tel. (____) _____
D M Y

PRIMARY INSURANCE

Ins. Company: _____ Tel. (____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID#: _____

Max Cov. _____ % coverage for _____Basic _____Maj. Restorative _____Orthodontic

SECONDARY INSURANCE

Ins. Company: _____ Tel. (____) _____

Employer/Policy Holder: _____ Ins. Yr. End: _____

Policy#: _____ Certificate#: _____ ID#: _____

Max Cov. _____ % coverage for _____Basic _____Maj. Restorative _____Orthodontic

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependents. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____

Signature ☐ Self ☐ Parent/Guardian Print name Date