WELCOME TO OUR DENTAL OFFICE

Date ___________________

PLEASE PRINT.

PID# ________ Office Use Only

REGISTRATION INFORMATION: This information will enable us to maintain communication with you.

The patient is an: Adult /Child/Adult under guardianship (circle one) Name of Guardian: ______________________________

Name: ________ (last) ________ (first) ________ (middle initial) Dr. Mr. Mrs. Ms. Miss (circle one)

Prefers to be called: ___________________________ Language Preference: ___________________

Address: ________ (street) ________ (apt#) ________ (city) ________ (province) ________ (postal code)

Home Phone #: ( ) _____________________ Business Phone #: ( ) _______________________ Ext: __________

Cell Phone #: ( ) ________________________ Email Address: ____

May we call you at work? Yes/No Best Way to Contact You (circle one): home/work/cell/email

Date of Birth: M________D________Y________ How did you hear about us? _____________________________

Are other family members patients at our office? Yes/No Names: ____

MEDICAL INFORMATION: This information will enable us to make any essential contacts.

Family Physician: ____ Phone: ( ) _________________________

Medical Specialist (if presently under care): _________________________________ Phone: ( ) ___________________

In case of emergency, please contact: ________ (name) ________ (relationship to patient) Phone: ( ) ___________________

Nearest relative not living with you: ________ (name) ________ (relationship to patient) Phone: ( ) ___________________

Reason for today's visit (circle one): Emergency/Examination/Other ____

Is there a dental problem that you would like treated as soon as possible? ____

FINANCIAL INFORMATION: This information is necessary to process invoices and apply payments. <u>Please complete all information if different from above</u>.

Person responsible for account (circle one): Self/Spouse/Parent/Other

Name: ________ (last) ________ (first) ________ (middle initial) Phone: ( ) ______________________

Address: ________ (street) ________ (apt#) ________ (city) ________ (province) ________ (postal code)

Employed by: ____ Business Phone: ( ) _________________________

Driver's Licence Number: ___________________________________ Health Card #: ______________________________

OFFICE PAYMENT POLICY: Payment is due in full at the time of the appointment. We DO NOT accept payment directly from your insurance company, with the exception of government assistance programs. We accept CASH, VISA, MASTERCARD and DIRECT DEBIT. No personal cheques will be accepted. If you will not be with your child personally at their appointment, payment arrangements must be made in advance. Children under the age of 16 must be accompanied by an adult to all appointments. **CANCELLATION POLICY:** We require 2 full business days notice for any changes to appointments. A charge will be applied for broken/missed appointments without advance notification.

I understand and agree to the policies listed above. ________ (print name) ________ (signature)

I have primary dental insurance coverage: Ins. Co. _________________ Name of Subscriber: ______________________________

Date Of Birth: __________ Group #: _________________________ Certificate #: ______________________ Division #:__________

I have secondary dental insurance coverage: Ins. Co. _________________ Name of Subscriber: ______________________________

Date Of Birth: __________ Group #: _________________________ Certificate #: ______________________ Division #:__________

I have dental coverage under one of the following Government Assisted Programs (circle one):

ODSP/Ontario Works (Basic or Emergency)/CINOT (Health Unit Children's Program)/Veteran's Affairs/NIHB/CAS

______________________________________ ________________________

Signature of Patient, Parent or Guardian **Date**

I authorize release, to my dental benefits plan admin & the CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named dentist. This authorization shall continue in effect until the undersigned revokes the same.