WELCOME TO OUR DENTAL OFFICE

Date _____

PID# _____ Office Use Only

PLEASE PRINT.

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

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: _____ Phone: ( ) _____
(name) (relationship to patient)

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

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: _____ Phone: ( ) _____
(last) (first) (middle initial)

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.