PATIENT'S NAME _____
Last First Initial Date of Birth

IF CHILD PARENT'S NAME _____
Last First Initial Date of Birth

HOW DO YOU WISH TO BE ADDRESSED: _____

Single ____ Married ____ Separated____

Divorced ____ Widowed ____ Minor ____

RESIDENCE - STREET _____

CITY_____ PROVINCE _____ POSTAL CODE _____

BUSINESS ADDRESS_____

TELEPHONE: RES. _____ BUS. _____

PATIENT EMPLOYED BY: _____

PRESENT POSITION _____

SPOUSE / PARENT NAME _____

SPOUSE EMPLOYED BY: _____

PRESENT POSITION _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT _____

DRIVER LICENSE NO. _____

METHOD OF PAYMENT: Cheque ____ Credit Card ____ Cash ____

PURPOSE OF VISIT: Examination ____ Emergency ____

OTHER FAMILY MEMBERS IN THIS PRACTICE _____

_____

WHOM MAY WE THANK FOR THIS REFERRAL_____

PATIENT SOCIAL INSURANCE NO. _____

SOMEONE TO NOTIFY IN CASE OF EMERGENCY NOT LIVING WITH YOU

_____ PHONE# _____

MAY WE CALL YOU AT WORK TO ARRANGE AN APPOINTMENT? _____

BEST TIME FOR APPOINTMENTS _____

ARE YOU AVAILABLE ON SHORT NOTICE FOR AN APPOINTMENT? _____

DENTAL INSURANCE 1ST

EMPLOYEES NAME

_____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____

YRS. _____

NAME OF INSURANCE CO.

_____

GROUP POLICY/PLAN# _____

DIVISION # _____

CERT.# /SIN/ or ID#

_____

PATIENT ID#

_____

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEES NAME

_____

EMPLOYEE DATE OF BIRTH _____

EMPLOYER _____

YRS. _____

NAME OF INSURANCE CO.

_____

GROUP POLICY/PLAN# _____

DIVISION # _____

CERT.# /SIN/ or ID#

_____

PATIENT ID#

_____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary. I understand that responsibility for payment for the dental services provided for myself or my dependents is mine, and I will assume responsibility of fees associated with these services. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor

APPOINTMENT TIME(S) WILL BE RESERVED ESPECIALLY FOR YOU. IF YOU UNABLE TO KEEP THE APPOINTMENT(S) WE WILL REQUIRE A MINIMUM OF 24 HOURS NOTICE, OTHERWISE IT MAY BE NECESSARY TO CHARGE YOU FOR A MISSED APPOINTMENT.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ *DATE* _____

PLEASE PRINT NAME _____ *DATE* _____

AUTHORIZATION FOR EDI: I authorize release, to my insuring company plan administrator, the information contained in claims submitted electronically.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN: _____

MED ALERT

REGISTRATION