NEW PATIENT INFORMATION

NAME _____ MALE __ FEMALE __ DATE OF BIRTH _____

HOME ADDRESS_____CITY_____PROVINCE_____

POSTAL CODE _____ HOME # _____ WORK # _____ CELL # _____

EMAIL ADDRESS _____

PLACE OF WORK _____WORK ADDRESS_____

ARE YOU A FT/PT COLLEGE OR UNIVERSITY STUDENT?_____ IF YES, WHERE? _____

HOW DID YOU HEAR OF US? _____ IF YOU HAVE BEEN REFERRED WHO MAY WE THANK_____

OTHER IMMEDIATE FAMILY MEMBERS WHO ARE PATIENTS HERE _____

REASON FOR THIS VISIT _____

DATE OF LAST DENTAL VISIT_____DATE OF LAST CLEANING_____

DATE OF LAST DENTAL X-RAYS_____ DATE OF LAST PANOREX_____

DENTAL INSURANCE – 1ST PLAN

EMPLOYEE NAME_____ EMPLOYEE DATE OF BIRTH_____

EMPLOYER_____EMPLOYER 'S PHONE NUMBER_____

NAME OF INSURANCE COMPANY_____ POLICY/GROUP #_____

CERTIFICATE/ID# _____

DENTAL INSURANCE – 2ND PLAN

EMPLOYEE NAME_____ EMPLOYEE DATE OF BIRTH_____

EMPLOYER_____EMPLOYER 'S PHONE NUMBER_____

NAME OF INSURANCE COMPANY_____ POLICY/GROUP #_____

CERTIFICATE/ID# _____

FINANCIAL INFORMATION

- PAYMENT IN FULL IS DUE AT TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS ARE MADE AND APPROVED
- AS LONG AS WE HAVE YOUR INSURANCE DETAILS WE WILL SUBMIT TO YOUR INSURANCE AND ASK THAT YOU PAY AMOUNT NOT COVERD AT EACH VISIT. IF WE DO NOT HAVE YOUR INSURANCE DETAIL YOU WILL BE REQUIRED TO PAY AT VISIT AND GET REINBURSED FROM YOUR INSURANCE COMPANY

FEDERAL PRIVACY ACT CONSENT

I,_____AGREE AND CONSENT TO CONSULTATION WITH OTHER HEALTH PROFESSIONALS, AND THE SHARING OF PERTINENT INFORMATION WHEN THIS IS CONSIDERED NECESSARY TO ENSURE THE COMMUNITY OF THERAPY, AND THE ACHIEVEMENT OF OPTIMUM AND SAFE THERAPY.

PATIENT OR GUARDIAN'S SIGNATURE_____ DATE_____