Welcome/ Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us we will be happy to help. Patient # SS#/SIN. Patient Information (CONFIDENTIAL) Date_ Birthdate Home Phone Name . Address City_ Email Cell Phone. Separated
State/
Prov.____ Check Appropriate Box: Minor Single Married Divorced ☐ Widowed _Full Part □Time □ Time If Student, Name of School/College _ Patient or Parent/Guardian's Employer _ Work Phone State/ Prov. _ Business Address City Work Phone. Spouse or Parent/Guardian's Name _ __ Employer _ Whom may we thank for referring you? _ Person to contact in case of emergency _ Phone Responsible Party Relationship Name of Person Responsible for this Account to Patient Address. Home Phone Cell Phone Email_ Driver's License#_ Birthdate . Financial Institution. Work Phone _ SS#/SIN **Employer** Is this person currently a patient in our office? \square Yes \square No For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

□ Cash	☐ Personal Check	Credit Card □ VISA	☐ MasterCard	\square I wish to discuss the office's payment policy.
Insura	ance Inform	nation		
Name of Insured				Relationship to Patient
BirthdateSS#/SIN				
Name of Employer			_ Union or Local# _	Work,Phone
Address of Employer			_ City	State/ Zip/ Prov. P.C.
Insurance Company			_ Group#	Policy/ID#
Ins. Co. Address			_ City	Statel Zipl Prov. P.C.
How much is your deductible? How much have			e you used?	Max. annual benefit
DO YOU HAVE ANY ADDITIONAL INSURANCE? \square Yes \square No IF YES, COMPLETE THE FOLLOWING:				
Name of Insu	red			Relationship to Patient
Birthdate SS#/SIN				Date Employed
Name of Employer		_ Union or Local# _	Work Phone	
Address of Employer		_ City	State/ Zip/ Prov. P.C.	
Insurance Company			_ Group#	Policy/ID#
Ins. Co. Address			_ City	State) / 10/
How much is your deductible?		How much have	vou used?	Max. annual benefit

Over Please