WELCOME TO OUR PRACTICE

The following information is strictly confidential for our records only. PLEASE PRINT

Name:_ _____ _____ _____ Date: _____
Last First dd mm year

Address: _____
Suite City Postal Code

Date of Birth: _____/ ____/ _____ Home Tel: _____Work Tel:_____
dd mm year

Cell: _____ E-mail Address: _____

Driver's License #: _____ DRIP #: _____

Employer:_____ Occupation: _____

Emergency Contact:_____ Relationship: _____ Tel: _____

Spouse's Name: _____ Tel: _____

Physician's Name: _____ Tel: _____

Pharmacy: _____ Tel: _____

Referred by:_____

Reason for Visit: E1 Comprehensive exam/consultation ❑ Specific reason: describe: _____

I agree and understand that my records of treatment may be shared with other health care professionals or dental insurance companies as necessary.

Signature: _____

Person responsible for financial matters: ▫ Self ▫ Spouse ❑ Parent/Guardian

Do you have a Dental Plan/Insurance? ❑ No ❑ Yes (If yes, please fill below.)

DENTAL PLAN/INSURANCE "INFORMATION

Subscriber's Name: _____Subscriber's Date of Birth: ____
dd mm year

Employer:_____

Insurance/Benefit Company: _____Group or Policy #:_____

I.D. or Certificate #: _____ SIN: _____