NEW PATIENT FORM

Your cooperation in completing the questionnaire is essential to provide you with safe and appropriate dental care, All information is strictly confidential. A member of our team will be able to assist you with the completion of the form. PLEASE PRINT

PATIENT NAME (SURNAME, GIVEN): ______________________________

PREFERRED NAME: ______________________________

BIRTHDATE (DD/MM/YY): ____________

HOME ADDRESS(NUMBER, STREET,CITY,PROVINCE):______________________________

____

POSTAL CODE: ______________ CELL: ______________

CONTACT EMAIL: ______________ EMERG: ______________

May we leave a voicemail regarding your appointment at these numbers? ❏ Yes ❏ No

Are you likely to be available on short notice for future appointments or changes? ❏ Yes ❏ No

We would like to send you email and text communication which may include appointment confirmations, newsletters, upcoming events, and important notifications. Check the box if you would like to receive future email and text communications from us. ❏

IN CASE OF EMERGENCY NOTIFY: ______________

PHONE:______________ RELATION: ______________

HOW DID YOU HEAR ABOUT US?

- ❏ Friend
- ❏ Staff member at our office
- ❏ website/internet
- ❏ Family member
- ❏ Patient at our office
- ❏ Advertisement
- ❏ Colleague
- ❏ Referral from health professional
- ❏ Saw sign/ office in person
- ❏ other:______________________________

Office policy: Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

______________________________ ______________

Signature: ❏ Patient ❏ Parent ❏ Guardian ❏ Caregiver Date

INSURANCE INFORMATION (IF THE PATIENT HAS A DENTAL PLAN, PLEASE COMPLETE THE FOLLOWING)

PRIMARY:

SUBSCRIBER:______________________________

RELATION:______________________________

INSURANCE CO:______________________________

POLICY PLAN:______________________________

DIVISION,SECT. #:______________________________

SUBSCRIBER ID:______________________________

SECONDARY:

SUBSCRIBER:______________________________

RELATION:______________________________

INSURANCE CO:______________________________

POLICY PLAN:______________________________

DIVISION,SECT. #:______________________________

SUBSCRIBER ID:______________________________