WELCOME TO OUR PRACTICE !

Name: _____ _____ _____ _____
First Middle Last Preferred name

Address: _____
City Province/State Postal Code

Date of Birth: _____ Sex: M ☐ F ☐ Marital Status: _____
m d y

Home Phone: _____ Work Phone: _____ Cell Phone: _____

e-mail address: _____ website: _____

PREFERRED METHOD OF CONTACT: ☐ e-mail ☐ cell phone ☐ home phone ☐ work

Occupation: _____ Employer: _____

How did you hear about us? ☐ Ad ☐ Walk-by ☐ Website ☐ Facebook ☐ family or friend

Referred by: _____

Are you happy with your smile? Yes No
If not, what would you like to change? _____
Are you interested in any cosmetic procedures: ☐ Botox ☐ veneers ☐ Invisalign

DENTAL INSURANCE

❑ None

Primary Dental Insurance

Policy Holder's Name _____
Relationship to patient _____
Date of Birth: _____
Insurance Company Name _____
Group / Policy # _____
Division # _____
ID / Certificate # _____

Secondary Dental Insurance

Policy Holder's Name _____
Relationship to patient _____
Date of Birth: _____
Insurance Company Name _____
Group / Policy # _____
Division # _____
ID / Certificate # _____

Consent for Treatment and Office Policies

I hereby consent to the performing of the dental and oral surgical procedures agreed to be necessary and advisable, with the use of local anaesthetic when indicated. I am aware that I am responsible for full payment of fees for services provided, unless prior arrangements have been made, and will be responsible for any insurance reimbursements. As a courtesy to you, our office will send all applicable claims on your behalf to your dental insurance plan, and I will assume full responsibility for fees associated with any procedures not covered by my plan.

I am aware that there may be a charge of $75.00 per hour for any missed appointments or appointment changes/cancellations with less than 48 business hours notice.

Patient/Parent/Guardian: _____ Date: _____
(signature)

_____
(print name)