PATIENT INFORMATION

WELCOME TO OUR DENTAL OFFICE

ALL INFORMATION IS CONFIDENTIAL

The patient is an: ☐ Adult ☐ Child ☐ Adult under guardianship Name of Guardian: _____

Name: _____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss
(Last) (First) (Initial)

Address: _____
(Street) (City) (Province) (Postal code)

Home Phone: _____ Work Phone: _____

Cellular Phone: _____ E-Mail: _____

PERSONAL INFORMATION

Date of Birth: M_____D_____Y_____ Age: _____ Sex: _____ Marital Status: _____

Occupation: _____ Employer: _____

Are there other family members who are patients at our office? _____

How did you hear about our office? _____

MEDICAL INFORMATION

Family Physician: _____ Phone: _____

Medical Specialist (if presently under care): _____ Phone: _____

Emergency contact: _____ Relationship: _____ Phone: _____

FINANCIAL INFORMATION

Person responsible for account: ☐ Self ☐ Spouse ☐ Parent Please complete the following information if **different** than above

Name: _____ Phone: _____
(Last) (First) (Initial)

Address: _____
(Street) (City) (Province) (Postal code)

Employed by: _____ Phone: _____

PRIMARY DENTAL INSURANCE			**SECONDARY DENTAL INSURANCE**		
Sub's name:		I.D.:	Sub.'s name:		I.D.:
Employer:		Ins. Year End:	Employer:		Ins. Year End:
Ins. Co:		Yearly Max.:	Ins. Co:		Yearly Max.:
Policy #:		Recall Freq.:	Policy #:		Recall Freq.:
Cert. #:		Post. Comp.:	I.D. #:		Post. Comp.:
% Basic	% Major	#units of perio/yr.	% Basic	% Major	#units of perio/yr.