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 Information (CONFIDENTIAL)    Date		The Section of the Se	Patient #
Name Birthdate Borne Phone States City Prov Proc.   States   State	D ' T	SS#/SIN	
Cell Phone   Check Appropriate Box   Minor   Single   Married   Divorced   Widowed   Separated   State   Full   Part   Prov.	Patient Injorma	Date	
Cell Phone   Check Appropriate Box   Minor   Single   Married   Divorced   Widowed   Separated   State   Full   Part   Prov.	Name	Birthdate _	Home Phone
Check Appropriate Box   Minor   Single   Married   Divorced   Widowed   Separated   State/   Full   State/   St	Address	City	ProvP.C
Patient or Parent/Guardian's Employer  Susiness Address  City  Prov  PC  Spouse or Parent/Guardian's Name  Employer  Work Phone  Sushom may we thank for referring you?  Person to contact in case of emergency  Phone  Relationship to Patient  Address  Home Phone  Prov  Relationship to Patient  Address  Home Phone  Driver's License#  Birthdate  Financial Institution  SS#/SIN  Is this person currently a patient in our office?    Yes   No  For your convenience, we offer the following methods of payment. Please check the option you prefex Payment in full at each appointment.  Cash   Personal Check   Credit Card   VISA   MasterCard   I wish to discuss the offices payment policy.  Insurrance Information  Name of Insured  SS#/SIN   Date Employed  Work Phone   State   Tipl  The City   Prov   PC  Insurance Company   Group # Policy/ID #  Since Co. Address   City   State   Tipl  Prov   Prov   PC  Prov   Prov   PC  Relationship to Patient    DO YOU HAVE ANY ADDITIONAL INSURANCE?   Yes   No   If YES, COMPLETE THE FOLLOWING:  Birthdate   SS#/SIN   Date Employed  Work Phone   State   Tipl  The Continued   Relationship to Patient    DO YOU HAVE ANY ADDITIONAL INSURANCE?   Yes   No   If YES, COMPLETE THE FOLLOWING:  Name of Employer   Union or Local #   State   Tipl  The Continued   Relationship to Patient    DO YOU HAVE ANY ADDITIONAL INSURANCE?   Yes   No   If YES, COMPLETE THE FOLLOWING:  Name of Employer   Union or Local #   State   Tipl  The Continued   Prov   Prov   Tipl  The Continued   Prov   Tipl			
Patient or Parent/Guardian's Employer  Susiness Address  City  Prov  PC  Spouse or Parent/Guardian's Name  Employer  Work Phone  Sushom may we thank for referring you?  Person to contact in case of emergency  Phone  Relationship to Patient  Address  Home Phone  Prov  Relationship to Patient  Address  Home Phone  Driver's License#  Birthdate  Financial Institution  SS#/SIN  Is this person currently a patient in our office?    Yes   No  For your convenience, we offer the following methods of payment. Please check the option you prefex Payment in full at each appointment.  Cash   Personal Check   Credit Card   VISA   MasterCard   I wish to discuss the offices payment policy.  Insurrance Information  Name of Insured  SS#/SIN   Date Employed  Work Phone   State   Tipl  The City   Prov   PC  Insurance Company   Group # Policy/ID #  Since Co. Address   City   State   Tipl  Prov   Prov   PC  Prov   Prov   PC  Relationship to Patient    DO YOU HAVE ANY ADDITIONAL INSURANCE?   Yes   No   If YES, COMPLETE THE FOLLOWING:  Birthdate   SS#/SIN   Date Employed  Work Phone   State   Tipl  The Continued   Relationship to Patient    DO YOU HAVE ANY ADDITIONAL INSURANCE?   Yes   No   If YES, COMPLETE THE FOLLOWING:  Name of Employer   Union or Local #   State   Tipl  The Continued   Relationship to Patient    DO YOU HAVE ANY ADDITIONAL INSURANCE?   Yes   No   If YES, COMPLETE THE FOLLOWING:  Name of Employer   Union or Local #   State   Tipl  The Continued   Prov   Prov   Tipl  The Continued   Prov   Tipl	Check Appropriate Box: Minor	□ Single □ Married □ Divorced □ Wid	dowed Separated Full Part
Spouse or Parent/Guardian's Name	If Student, Name of School/Col <mark>lege</mark>	City	Prov. Time Time
Spouse or Parent/Guardian's Name	Patient or Parent/Guardian's Employ	er	Work Phone
Whom may we thank for referring you?  Person to contact in case of emergency  Responsible Party  Name of Person Responsible for this Account  Address  Home Phone  Cell Phone  Driver's License#  Birthdate  Financial Institution  Email  Work Phone  SS#/SIN  Is this person currently a patient in our office?   Yes   No  For your convenience, we offer the following methods of payment. Please check the option you prefex Payment in full at each appointment.  Cash   Personal Check   Credit Card   VISA   MasterCard   I wish to discuss the offices payment policy.  Insurance Information  Relationship  to Patient  Birthdate   SS#/SIN   Date Employed  Work Phone   State/or	Business Address	City	ProvP.C
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Responsible Party Name of Person Responsible for this Account Address	Whom may we thank for referring y	ou?	
Name of Person Responsible for this Account  Address	Person to contact in case of emergen	cy	Phone
Name of Person Responsible for this Account  Address	Responsible Par	rtv	
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Cell Phone   Driver's License#   Birthdate   Financial Institution   SS#/SIN			
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Birthdate SS#/SIN	Cash Personal Check  Insurance Infor	Credit Card □ VISA □ MasterCard	$\Box$ I wish to discuss the office's payment policy.
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Ins. Co. Address City State/ Prov			
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DO YOU HAVE ANY ADDITIONAL INSURANCE?    Yes		•	
Name of Insured	How much is your deductible?	How much have you used?	Max. annual benefit
Name of Insured to Patient	DO YOU HAVE ANY ADDITION	AL INSURANCE? Yes No	IF YES, COMPLETE THE FOLLOWING:
Date Employed   Date Employed   Name of Employer   Union or Local #   Work Phone   State/   Zip/   Prov.   P.C.	Name of Insured		Relationship to Patient
Name of Employer         Union or Local #         Work Phone State/ Zip/ Prov.         Zip/ Prov.         Prov.         P.C.         Prov.         P.C.         Prov.         P.C.         Insurance Company         Group #         Policy/ID #         State/ Zip/ Prov.         P.C.         Prov.         P.C.         Prov.         P.C.         P.C.         P.C.         Prov.         P.C.			
Address of Employer         City         State/Prov.         Zip/Prov.         P.C.           Insurance Company         Group #         Policy/ID #         State/Zip/Prov.         Zip/Prov.         P.C.           Ins. Co. Address         City         Prov.         P.C.			l#Work Phone
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