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.

| | | | we will be happy to help |
|---|--------------------------------------|----------------------------|--|
| | | | Patient # |
| D. C. | SS#/SIN Date | | |
| Patient Informa | | | |
| | | Birthdate | _ Home Phone State/ Zip/ Prov P.C |
| | | City | |
| Email | | | Cell Phone |
| Check Appropriate Box: ☐ Minor | | | State/ Full Part |
| If Student, Name of School/College | | | |
| Patient or Parent/Guardian's Emplo Address | ryer | City | Work Phone State/ Zip/ Prov. DC |
| | e or Parent/Guardian's Name Employer | | |
| Whom may we thank for referring y | | • • | |
| Person to contact in case of emergen | | | |
| | | | |
| Responsible Par | Relationship to Patient | | |
| | | | |
| Address | | | |
| Email | | | Policiana de Adrida de Carte d |
| Driver's License # | | | |
| Employer | | | 35#/31N |
| Insurance Infor | Credit Card □ VISA □ *mation | MasterCard ☐ I wish to dis | cuss the office's payment policy. |
| Name of Insured | | | |
| Birthdate | | | 1 2 |
| Name of EmployerAddress of Employer | | Conton or Local # | Work Phone State/ Zip/ |
| | | | |
| Insurance Company | | | State/ Zip/ |
| | | _City | |
| How much is your deductible? | How much have | e you used? M | ax. annual benefit |
| DO YOU HAVE ANY ADDITION | JAL INSURANCE? | ☐ No IF YES, COMPLE | TE THE FOLLOWING: |
| Name of Insured | | | Relationship to Patient |
| Birthdate | SS#/SIN | | |
| Name of Employer | Union or Local # | | Work Phone State/ Zip/ Prov P.C |
| Address of Employer | | _City | Prov P.C |
| Insurance Company | | _ Group # | Policy/ID # |
| Ins. Co. Address | | _City | State/ Zip/ Prov. P.C. |
| How much is your deductible? | How much have | e you used? M | ax. annual benefit |