

In an effort to serve you better, we ask that you please complete the following. We will be glad to assist you. PLEASE PRINT.

A parent or guardian will be responsible for decisions on my treatment. \Box Yes \Box No

PATIENT INFORMATION:

Name:		
First	Initial	Last
Address:		
Apartment		Street
City	Province	Postal Code
Date of birth: d/m_	/у Н	ome Phone()
Employer:	W	/ork Phone ()x
Occupation:	C	ell Phone ()
Email address:		
How did you hear about u	sś	
Emergency Contact:	t	elephone ()
Referring Dentist:	t	elephone ()
Dentist: (if different)	t	elephone ()
PERSONAL INFORMATION	AND ELECTRONIC DO	DCUMENTS ACT
I authorize release to my d	ental benefit plan a	dministrator and the CDA, information
contained in claims submi	tted electronically. I	also authorize the communication of
information related to the	coverage of services	s described to the named dentist. This
authorization shall continu	e in effect until the u	ndersigned revokes the same.

Signature of Patient (or Parent/Guardian)

Date

PLEASE TURN OVER

FINANCIAL INFORMATION

Method of payment:

Person responsible for financial matters: □ Self □ Spouse □ Parent/Guardian □ Other

Subscriber:	Date of Birth: d/ m/ y
Insurance Company:	Telephone ()
Employer:	
Policy #	Certificate #

FINANCIAL ARRANGEMENTS

For all appointments, payment is due on the day of your treatment. For your convenience, we welcome VISA, Master Card and direct debit as payment. We will complete any necessary insurance forms for you in order to maximize your reimbursements. If you experience lengthy delays in receiving reimbursement, you should phone the insurance company directly.

We try our best to be as accurate as possible in estimating the cost of treatment. However, because of the very nature of surgical procedures, it is sometimes difficult to predict the exact course of surgery and treatment and therefore fees can sometimes change. We need this flexibility in order to provide you with the best quality of care possible.

All patients receiving treatment provided with sedation are required to make payment prior to receiving any medications. Our team is here to make processing insurance claims and payments as simple as possible for you and would be happy to answer any questions you may have.

I certify by my signature below that I have read and understand the above policy and agree to abide by the terms and conditions outlined therein.

Signature of Patient (of Parent/Guardian)

Date

Print Name