Patient Name ______________________________________
(Include Initial)

**Patient Information**

Marital Status
Single ☐ Married ☐ Common Law ☐ Other ☐
Spouse/Partner's Name ___________________________
Address__________________________________________
City ________________________Postal Code_________
Occupation ______________________________________
Health Card No.________________________________
Do you have family members or friends that are patients of this office?
No ☐ Yes ☐
Referred by ______________________________________

**Contact Information**

Home Phone (____) ____________________________
Work Phone (____) ____________________________
Cell Phone (____) _____________________________
Email Address __________________________________

Please indicate the best time to contact you for appointments:
Anytime of the day ☐ Days Only ☐ Evenings Only ☐
In case of an emergency, contact:
Name _______________________Relationship_____________
Telephone (___) ________________________________________

**Responsible Party**

☐ Self ☐ Spouse ☐ Other
If not self please complete the following:
Name ____________________________________________
Address _________________________________________
City ____________________________________________
Employer _________________________________________
Phone: Home________________ Work ________________
Is this person currently a patient at our office? Yes ☐ No ☐

Adult ☐ Child ☐ Date of Birth _______________________

**Dental Insurance (Primary Coverage)**

Employee Name ___________________________________
Employee Date of Birth _________________________________
Employer _____________________________________________
Insurance Company______________________________________
Address _____________________________________________
_____________________________________________________

Telephone ___________________________________
Group or Policy No. _________________________________
Certificate or ID No. ________________________________

**Dental Insurance (Additional Coverage)**

Employee Name ______________________________________
Employee Date of Birth _______________________________
Employer _____________________________________________
Insurance Company ___________________________________
Address _____________________________________________
_____________________________________________________
Telephone (___) ____________________________
Group or Policy No. ___________________________________
Certificate of ID No. _________________________________

**Payment Information**

Method of Payment:
Cash ☐ Cheque ☐ Credit Card ☐

Coverage:
Basic _____% Ortho _____%
Major _____% Endo _____%
Other _____% Perio _____%

Maximum Coverage __________________________________

Check up Frequency: Every _____ Months