Dental on the Avenue.

New patient information (confidential)

Name: _____ Date: _____

Address: _____ Prov.: _____ Postal Code: _____

Home phone: _____ Cell Phone: _____ Email: _____

Work phone: _____ Employer: _____ S.I.N.: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital status: _____

Spouse name or parent's name if minor: _____

Person to contact in case of emergency: _____ Phone: _____

If student, name of school: _____ Grade: _____

Whom may we thank for referring you: ☐ Internet ☐ Phone Book ☐ Walk in ☐ Family/Friend _____

Responsible party *(Please complete all information if different from above)*

Name: _____ Relationship to patient: _____

Address: _____ Home phone: _____

Driver's Lic.#: _____ Date of Birth: _____ S.I.N.: _____

Employer: _____ Work phone: _____

Is this person currently a patient in our office? ☐ YES ☐ NO

Insurance information

Name of insured: _____ Date of birth: _____

Insurance company: _____

Employer/group policy holder: _____ Insurance year end: _____

Group/individual policy#: _____ Certificate #: _____

I.D./S.I.N.: _____ Annual maximum: $_____ Annual deductible: $_____

Percentage coverage: Basic: _____% Major rest.: _____%

Recall frequency: _____ Polish/fluoride frequency: _____ Scaling/root planing limit: $ _____ # units: _____

Do you have additional insurance? ☐ YES ☐ NO If yes, complete the following:

Name of insured: _____ Date of birth: _____

Insurance company: _____

Employer/group policy holder: _____ Insurance year end: _____

Group/individual policy#: _____ Certificate #: _____

I.D./S.I.N.: _____ Annual maximum: $_____ Annual deductible: $_____

Percentage coverage: Basic: _____% Major rest.: _____%

Recall frequency: _____ Polish/fluoride frequency: _____ Scaling/root planing limit: $ _____ # units: _____

_____ REFERRED BY: _____

Signature (Parent or guardian if minor)

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