Patient Registration

All information is confidential.

Last Name: _____ First Name: _____

Preferred Name: _____ Address: _____

City: _____ Postal Code: _____ Employer: _____

Date of Birth (D/M/Y): _____ Gender: _____ Marital Status: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ **E-mail**: _____

Parent/Guardian (if applicable): _____ Phone #: _____

Emergency Contact: _____ Phone # _____

Whom may we thank for referring you? _____

Person responsible for account: _____

Our methods of payment include: Cash. Cheque. Debit. Visa. Mastercard. Amex.

If you have any dental benefits please present card or numbers to admin team with this form.

Please note: Our office will be pleased to direct bill your insurance company on your behalf. However,

Knowledge of your specific insurance coverage and maximums of coverage is your responsibility.

Date: _____ Signature: _____