

# WELCOME TO OUR DENTAL OFFICE

(For office use only)

I.D. #

MEDICAL ALERT Y  N

Date \_\_\_\_\_

The information that is requested on this Questionnaire, Dental History and Medical History is essential to providing you with the highest standard of dental care. The protection and privacy of your personal information is important to our office and we are committed to collecting, using and disclosing this information responsibly. PLEASE PRINT.

## REGISTRATION INFORMATION - This information will enable us to maintain communication with you.

The patient is an: Adult  Child  Adult under guardianship  Name of Guardian: \_\_\_\_\_

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (initial) \_\_\_\_\_ Dr.  Mr.  Mrs.  Ms.  Miss

Prefers to be called: \_\_\_\_\_ Language Preference: \_\_\_\_\_

Address: (street) \_\_\_\_\_ (apt.#) \_\_\_\_\_ (city) \_\_\_\_\_ (province) \_\_\_\_\_ (postal code) \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Additional registration information if required by office: \_\_\_\_\_

Bus. Phone: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_ Employer: \_\_\_\_\_ May we call you at work?

Cell Phone: ( ) \_\_\_\_\_ Pager No: ( ) \_\_\_\_\_ E-Mail address: \_\_\_\_\_

Date of Birth: M \_\_\_ D \_\_\_ Y \_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Name of Spouse: \_\_\_\_\_

Preferred appointment time: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_

Are other family members patients at our office? Yes  Names: \_\_\_\_\_

## MEDICAL PRIORITY - This information will enable us to make any essential contacts.

Family Physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
(if presently under care)

In case of emergency, please contact: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Nearest relative not living with you: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Reason for today's visit? Examination  Emergency  Other  \_\_\_\_\_

Is there a dental problem you would like treated immediately? \_\_\_\_\_

## FINANCIAL INFORMATION - This information is necessary to process invoices and apply payments.

Person responsible for account: Self  Spouse  Other  **Please complete all information only if different than above.**

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (initial) \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Address: (street) \_\_\_\_\_ (apt.#) \_\_\_\_\_ (city) \_\_\_\_\_ (province) \_\_\_\_\_ (postal code) \_\_\_\_\_

Employed by: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Additional financial information if required by office: \_\_\_\_\_

METHOD OF PAYMENT (For office use only) CASH  CHEQUE  CREDIT CARD  OTHER

## PRIMARY DENTAL INSURANCE (Complete information only if required by office) SECONDARY DENTAL INSURANCE

PRIMARY DENTAL INSURANCE					SECONDARY DENTAL INSURANCE				
Subscriber's name:	D.O.B.		Subscriber's name:		D.O.B.				
Emp./Grp. policy holder:	Ins. yr. end		Emp./Grp. policy holder:		Ins. yr. end				
Ins. Co.	Tel.		Ins. Co.		Tel.				
Grp./Ind. policy No.	Cert. No.		Grp./Ind. policy No.		Cert. No.				
I.D.#	Max. Coverage.		I.D.#		Max. Coverage.				
% coverage: Basic	Maj. Rest.	Ortho.	Other	Other	% coverage: Basic	Maj. Rest.	Ortho.	Other	Other

PATIENT REGISTRATION

DENTAL HISTORY