The Dental Place

New Patient Form

In the effort to serve you better , we would ask that you complete the following.We will be glad to assist you.

Patient Information : A parent or guardian will be responsible for decissions on my treatment **Yes** **No**

Name				**Date Of Birth** _____/_____/_____.
	First	**Middle Initial**	**Last**	**D M Y**

Address		
	Street	**Apt #**

City	**Province**	**Postal Code**

Cell Ph:		**Home Ph:**		**Work Ph:**		

Email		**Preferred Method to contact**	**Phone Call**	**SMS/Watsapp**	**Email**

Please specify the preferred time of day for contacting you:_____

Emergency Contact **Ph:** **Relationship**_____.

Family Doctor **Ph:**

Referring Doctor **Ph:**

Please specify how did you learn about our office?

Patient Referred	**Google Ads**	**Google Listing**	**ValPak**	**Save.Ca**	**Flyer**	**Others**_____.

Payment Details:

Cash **Insurance** **Others.**_____.

if Insurance	**Individual**	**Group**	**ODSP**	**OW**	**HSO**	

Primary Insurance Details

Insurance Provider:_____. **Telephone** _____.

Policy #_____. **Certificate #**_____.

Employer_____. **Policy Holder**_____.

Secondary Insurance Details

Insurance Provider:_____. **Telephone** _____.

Policy #_____. **Certificate #**_____.

Employer_____. **Policy Holder**_____.

Print Name_____. **Signature**_____. **Date**_____.