PERSONAL INFORMATION

Name: Mr. O Mrs. O Ms. O Dr. O _____
(Given Name) (Family Name)

Address: _____

_____ Place of Birth: _____

Date of Birth:____/____/____ Height:_____ Weight:_____
D M Y

Telephone Residence:_____ Business:_____ Ext. _____

Cell:_____ Would you like text msg appointment confirmations? Yes O No O
(will begin summer 2014)

Email: _____

Would you like email appointment confirmations? Yes O No O

When is the best time to contact you? _____

Occupation:_____ Place of Business:_____

Referred by:_____

Person responsible for account: Self o Other o_____

Dental insurance: Yes o No o if Yes, insurance name_____

Group Policy # _____ SIN_____

Reason for today's visit: Examination o Emergency o

Other_____

Physician name_____ p.h.#_____

In case of emergency please notify:

_____
Name Relationship Telephone

PATIENT CONSENT

I, the undersigned, consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable, including the use of local anaesthetic as indicated, and I will assume responsibility for fees associated with these procedures.

Patient (Parent, Guardian) Signature: _____ Date: _____