DOWNTOWN DT DENTAL

PATIENT INFORMATION

Our goal is to provide exceptional patient care. Please complete the attached forms to help us personalize your dental care.

Thank you.

PERSONAL INFORMATION

Full Name:___________________________ Preferred Name:________________________
Date of Birth:_________________________ (Day/Month/Year)
Address:____
City:__________________________ Province:____________Postal Code:____________
Employer:___________________________ Occupation:____________________________
Home Phone:___________________ Work:_________________ Cell:_________________
Email:_______________________________
Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell ☐ Text Message ☐ Email
Emergency Contact Name:________________________ Phone Number____________
Relationship To You:_____________________________
Who Can We Thank For Referring You:____
Or Did You Find Us On Your Own? If So Please Indicate How:
____

INSURANCE INFORMATION

Primary Dental Insurance Information:
Name of Insurance Company:____
Name of Employer: ____
Name of Employee:____
Group/ Policy #:____
Certificate/ ID #:_____________________________________DIV #:________________
Patient Relationship to Insured:____
Insured's Date of Birth:______________________ (Day/Month/Year)

Secondary Dental Insurance Information:
Name of Insurance Company:____
Name of Employer: ____
Name of Employee:____
Group/ Policy #:____
Certificate/ ID #:_____________________________________DIV #:________________
Patient Relationship to Insured:____
Insured's Date of Birth:______________________ (Day/Month/Year)

Patient Signature:___________________________Date:__________________________