



New patient information (confidential)

Name: _____ Date: _____
Address: _____ Prov.: _____ Postal Code: _____
Home phone: _____ Email: _____ Driver's Lic.#: _____
Work phone: _____ Employer: _____ S.I.N.: _____
Date of Birth: _____ Age: _____ Sex: _____ Marital status: _____
Spouse or parent's name: _____ Employer: _____
Person to contact in case of emergency: _____ Phone: _____
If student, name of school: _____ Grade: _____
Whom may we thank for referring you: _____

Responsible party *(Please complete all information if different from above)*

Name: _____ Relationship to patient: _____
Address: _____ Home phone: _____
Driver's Lic.#: _____ Date of Birth: _____ S.I.N.: _____
Employer: _____ Work phone: _____
Is this person currently a patient in our office? YES NO

Insurance information

Name of insured: _____ Date of birth: _____
Insurance company: _____
Employer/group policy holder: _____ Insurance year end: _____
Group/individual policy#: _____ Certificate #: _____
I.D./S.I.N.: _____ Annual maximum: \$ _____ Annual deductible: \$ _____
Percentage coverage: Basic: _____% Major rest.: _____%
Recall frequency: _____ Polish/fluoride frequency: _____ Scaling/root planing limit: \$ _____ # units: _____

Do you have additional insurance? YES NO If yes, complete the following:

Name of insured: _____ Date of birth: _____
Insurance company: _____
Employer/group policy holder: _____ Insurance year end: _____
Group/individual policy#: _____ Certificate #: _____
I.D./S.I.N.: _____ Annual maximum: \$ _____ Annual deductible: \$ _____
Percentage coverage: Basic: _____% Major rest.: _____%
Recall frequency: _____ Polish/fluoride frequency: _____ Scaling/root planing limit: \$ _____ # units: _____

Signature of patient or parent if minor

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