



**Personal Information**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male \_\_ Female\_\_ Married\_\_ Single\_\_ Child\_\_ Other\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code \_\_\_\_\_

Phone (Home): \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Do any other immediate family members come to our office? \_\_\_\_\_

Whom can we thank for referring you to our office? \_\_\_\_\_

If you have dental insurance coverage please provide us with the information cards the insurance company has provided you with. Most insurance companies allow us to send in claims on your behalf on the day of service, but we do require your payment in full on the day of service. We offer visa, mastercard, debit and cash as methods of payment.

For your convenience, our office provides a few options to help you keep your appointments in mind. We offer text and or e-mail reminders or if neither of those options are available to you we will offer you a courtesy call 2 business days in advance of your appointment. Keeping this in mind, we do ask for 2 business day notice to change or cancel an appointment to avoid a charge on your account.

***Consent for Collection, Use and Disclosure of Personal Information***

I agree that this dental office has obtained informed consent from me with respect to the collection, use and disclosure of my personal health information. I have been provided with a copy of the consent form and agree that personal information may be collected, used and disclosed as set out in the Privacy Policy of this dental office.

Signature \_\_\_\_\_

Date \_\_\_\_\_