THE Tooth Doctors Rx
FAMILY & COSMETIC DENTISTRY

PATIENT REGISTRATION FORM

PERSONAL INFORMATION

LAST NAME:

BIRTH DATE:

FIRST NAME:

PREFERRED NAME:

MIDDLE INITIAL:

GENDER:

CONTACT INFORMATION

STREET:

HOME:

CITY:

BUSINESS:

PROVINCE

MOBILE:

POSTAL CODE:

OTHER:

EMAIL:

PREFERRED CONTACT:

EMERGENCY CONTACT

LAST NAME:

PHONE:

FIRST NAME:

RELATIONSHIP:

REFERRAL

HOW DID YOU HEAR ABOUT US:

DENTAL HISTORY

HOW OFTEN DO YOU BRUSH?

REASON FOR LAST VISIT:

HOW OFTEN DO YOU FLOSS?

OTHER DENTAL CONCERNS?

LAST TIME YOU VISITED THE DENTIST:

By providing a cell number and/or email, I authorize The Tooth Doctors to correspond with me in that manner. I understand that text messages and email communications are not secure forms of communication and that confidentiality of any text or email can not be ensured. I understand that this authority is to remain in effect until The Tooth Doctors has received written notification from me of its change or termination.

SIGNED

DATE

PATIENT REGISTRATION FORM

At The Tooth Doctors, payment is due the day treatment is provided. If you have dental insurance, we will gladly submit the claim electronically on your behalf. We accept Visa, MasterCard, Debit and Cash. Our fees are based on the ODA Fee Guide for the current year. If you have any questions regarding our fees, please inquire. Your appointment is time set-aside specifically for you with either our dentist or hygienist. We require 48 hours notice to cancel or reschedule an appointment. If you need to change or cancel an appointment, please call during normal business hours. If an appointment is cancelled with less notice or you do not show for your appointment, we reserve the right to charge a cancellation fee.

INSURANCE INFORMATION OF INSURED - **PRIMARY**

LAST NAME: ____________ INSURANCE CO: ____________

FIRST NAME: ____________ POLICY #: ____________

BIRTHDATE: ____________ ID #: ____________

EMPLOYER: ____________

INSURANCE INFORMATION OF INSURED - **SECONDARY**

LAST NAME: ____________ INSURANCE CO: ____________

FIRST NAME: ____________ POLICY #: ____________

BIRTHDATE: ____________ ID #: ____________

EMPLOYER: ____________

NAME (PLEASE PRINT)

I, ____________, state that I have completed all information forms accurately, without knowingly omitting any information. On the basis of confidentiality, I hereby consent to the release and transfer of any patient information and dental records within my file for dental insurance purposes or inter-practitioner communication. I agree that The Tooth Doctors have obtained informed consent from me with respect to the collection, use, and disclosure of my personal health information. If asked, I will be 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 at this dental office and is in accordance with the Personal Health Information Protection Act, 2004. I also authorize release, to my benefits plan administrator and CDA, information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to The Tooth Doctors.

SIGNED ____________ **DATE** ____________