



Patient Information Form

To serve you properly we will need the following information. All information will be strictly confidential. Please print

Patient's Last Name: _____ Patient's First Name: _____

Social Insurance Number: _____ Date of Birth (DD/MM/YR): _____ Gender: M F

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail: _____ Best number to call when we confirm your appointment: _____

Address: _____ City: _____ Postal Code _____

Occupation: _____ Name of Employer: _____

Spouse Name & Last Name (if applicable) _____

Name of the Contact Person in case of emergency: _____

Relationship to the patient: _____ Phone Number: _____

Is another member of your family or relative a patient at our practice? _____

Describe in your own words your present dental condition _____

If you were to change one thing about your mouth/teeth, what would it be? _____

Dental Benefits Information

A subscriber is the primary holder of the benefits. If you are on your spouse's benefit plan, your spouse would be the subscriber. Subscriber Name: _____

Subscriber's Social Insurance #: _____ Subscriber ID: _____ Subscriber Group #: _____

(If you are not the Subscriber) Your relationship to the Subscriber: _____

Subscriber's Employer: _____ Employer Phone Number: _____

Benefit Provider Name: _____ Benefit Provider Phone Number: _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

Referral Information

How did you find out about our practice? _____

Whom may we thank for referring you? _____