METROTOWN DENTAL CLINIC

NEW PATIENT INFORMATION FORM

Name: _____ Date: _____
Address: _____ City: _____
Prov.: _____ Postal Code: _____ Home phone: _____
Work phone: _____ Cell phone: _____
Email: _____ *Opt in Newsletter: ◯ Yes ◯ No
Date of birth: _____ Sex: _____ If child, parent's name: _____
Person to contact in case of emergency: _____
Relationship to Patient: _____ Phone: _____
If student, name of school: _____ Grade: _____
Whom may we thank for referring you: _____

Credit Card Info:
◯ Visa ◯ MC ◯ AMEX Card #: _____ Expiry Date: _____ CSV #: _____

Responsible Party ***(Please complete all information if different from above)***
Name: _____ Relationship to Patient: _____
Address: _____ City: _____
Prov.: _____ Postal Code: _____ Home phone: _____
Work phone: _____ Cell phone: _____
Date of birth: _____ Is this person currently a patient in our office? ◯ Yes ◯ No

Insurance Information
Name of insured: _____ Date of birth: _____
Insurance Company: _____
Insurance year end: _____ Policy #: _____ ID/Certificate #: _____
Annual maximum: $_____ Annual deductible: $: _____
Percentage coverage: Basic: _____% Major: _____% Ortho: _____%
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: _____
Insurance year end: _____ Policy #: _____ ID/Certificate #: _____
Annual maximum: $_____ Annual deductible: $: _____
Percentage coverage: Basic: _____% Major: _____% Ortho: _____%
Recall frequency: _____ Polish/fluoride frequency: _____
Scaling/Root Planing limit: $_____ #Units: _____

Once your appointment is set, a chair is booked and your dentist and staff are scheduled. If you are unable to keep your appointment, you must inform us at least <u>2 business days in advance</u> to avoid a charge. Missed appointments can result in <u>$100 fee.</u>

Signature of patient or parent if minor: _____