Guildford Family Dental

REGISTRATION FORM - (PLEASE PRINT AND COMPLETE FULLY)

PATIENT INFORMATION

Patient's last name:	First:	Middle initial:	❑ Mr. ❑ Mst ❑ Dr.	❑ Miss ❑ Ms. ❑ Mrs

Is this your legal name? ❑ Yes ❑ No	Personal Health Care #	Birth date: MM / DD / YR	Age:	Sex: ❑ M ❑ F

Apt /Street address:	City & Province	Postal code:

Home #	Work #	Cell #	Email Address

Occupation:	Employer:

Referred to clinic by (please check one box):	❑ Family/friend ❑ Website ❑ Family Dentist ❑ Other : _____

Name of referral:

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Are you covered with dental insurance? ❑ Yes ❑ No Do you have dual insurance? ❑ Yes ❑ No

Name of Primary insurance (if applicable):	Subscriber's name and birthdate:	Group no.:	ID or sin# no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Dep. #

Name of Secondary insurance (if applicable):	Subscriber's name and birthdate	Group no.:	ID or sin# no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Dep. #

IN CASE OF EMERGENCY

Name of next of kin or friend:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I certify that I have read and understand the above information to the best of my knowledge. The above questions and the health questionnaire have been accurately answered. I understand that providing incorrect information cans be dangerous to my health. I authorize the dentist too release any information including the diagnosis and the records of any treatment or examination rendered to me/or my child during the period of such dental care to third party payors and/or Health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that I am financially responsible to my dentist for the entire treatment rendered on my behalf or my dependents.

_____ _____

Patient/Guardian signature *Date*