New Client Registration

THE FOLLOWING INFORMATION IS REQUIRED TO ENABLE US TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE. ALL INFORMATION IS STRICTLY PRIVATE, AND IS PROTECTED BY DOCTOR-PATIENT CONFIDENTIALITY. YOUR DENTIST WILL REVIEW THE QUESTIONS AND EXPLAIN ANY THAT YOU DO NOT UNDERSTAND. PLEASE FILL IN THE ENTIRE FORM.

Contact Information

Client Full Name: _____

Street Address: _____ City: _____

Province: _____ Postal Code: _____

Date of Birth: _____ Gender: _____

Email Address: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Previous Dentist Information

Do you have a previous dentist? If yes, Yes□ No□

Previous Dentist's Name: _____

Previous Dentist's Address: _____

Insurance Information

Primary Insurance Info

Card Holder Name: _____ Card Holder Date of Birth: _____

Insurance Company Name: _____

Group #: _____ ID #: _____

Employer Name (not required): _____

Do you have secondary insurance? Yes□ No□

Secondary Insurance Info

Card Holder Name: _____ Card Holder Date of Birth: _____

Insurance Company Name: _____

Group #: _____ ID #: _____

Employer Name (not required): _____

Communication Consent

Preferred method of communication? Text □ Email □ Phone/Voice Mail □

□ I understand that email/texting is not a secure form of communication.
□ I consent to receiving reminders for appointments through text/email/VM
□ I understand I may opt out of emails/texts/VM at any time