Dentistry IN AURORA

Patient Information and Health History

In order to render an optimum health service, it is necessary to obtain a variety of personal information. All information obtained is kept strictly confidential. Please print all information.

Name ______________________ Preferred Name ______________________

☐ Female ☐ Male Title ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr Birthdate (D/M/Y)______________ Age________

Address ____

City, Province ______________________ Postal Code ______________________

E-mail ______________________________

Home Phone ______________________ Business Phone ______________________

Cell Number ______________________ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐Widow(er)

Occupation ______________________ Employer ______________________

Emergency Contact ______________________ Phone ______________________

Spouse ______________ Mother ______________ Father ______________

Do you have dental insurance? ☐ Yes ☐ No Name of Insured ______________________

Employer ______________________ Birthdate of Insured ______________________

Name of Insurance Carrier ______________________

Policy Number ______________________ Certificate Number ______________________

Who may we thank for your referral? ☐ Yellow Pages ☐ Web Site ☐ Health Care Provider ☐ Other ____________

Do you have other family members who are in our practice? ☐ Yes ☐ No If yes, who? ____________

Date of Last Dental Visit ______________ Name of previous Dentist ______________________