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 Birthdate (D/M/Y) _____ Age_____

Address _____

City, Province_____ Postal Code_____

Email_____

Home Phone _____ Business Phone _____ Cell Number _____

Occupation _____ Employer _____

Emergency Contact _____ Phone _____

Person responsible for this account _____

Do you have Dental Insurance ☐ Yes ☐ No

Name of Insured _____ Name of Insurance Carrier _____

Policy Number _____ Certificate Number _____

Do you have Secondary Insurance? ☐ Yes ☐ No Name of Insured _____

Name of Insurance Carrier_____ Birthdate (D/M/Y) _____

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? _____

Name of your previous Dentist _____ Telephone _____

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