Access Dental Care

Date:_____
D M Y

Patient is an: ❑ **Adult** ❑ **Child** ❑ **Adult Under Guardianship**
Name of Guardian_____

Name_____ Nickname_____
(First) (Last) (Initial)

Home Address_____
(Street) (Unit#) (City) (Province) (Postal Code)

Home Phone_____ Cellular Phone_____ Other Phone_____

Date of Birth_____ Age____ Sex____ Marital Status_____ Occupation:_____
D M Y

Email_____

Family Physician_____ Phone_____

Medical Specialist_____ Phone_____

Dental Insurance ❑ **Yes** ❑ **No**

1. **Primary Insurance Co. Name**_____ Phone_____

Insurance Mailing Address_____ Employer_____

Policy/Plan #_____ Cert./ID#_____ Divisions/Section #_____

Name _____ Date of Birth _____ Sex ____
(First) (Last) (Initials) D M Y

2. **Secondary Insurance Co. Name**_____ Phone_____

Insurance Mailing Address_____ Employer_____

Policy/Plan #_____ Cert./ID#_____ Divisions/Section #_____

Name _____ Date of Birth _____ Sex ____
(First) (Last) (Initials) D M Y

Person responsible for account: ❑ **Self** ❑ **Other** (Name) _____

Address_____
(Street) (Unit#) (City) (Province) (Postal Code)

Home Phone_____ Cellular Phone_____ Other Phone_____

In case of emergency: Please notify _____Relationship_____

Home Phone_____ Cellular Phone_____ Other Phone_____

Is any other member of your family or relative a patient with our practice?_____

Reason for today's visit? ❑ Dental Cleaning ❑ Whitening ❑ Sports Guard ❑ Examination ❑ Other_____

Referral Information

How did you hear about our Services? _____

Name of person/practitioner referring you to our practice: _____

PATIENT INFORMATION